Corrective Action Plan (CAP) Detail Report

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA	Audit Findings	8/15/2008	Open	Section 1 - Clinical PACE Elements		The CAP must clearly describe 1)established dietary policies and procedures for staff to follow, 2)establish internal controls to maintain a complete and correct dietary roster, 3)establish internal controls to ensure that the participant's clinical record is consistent with the diet ordered by the physician and the listings on the dietary roster, 4)establish internal controls to demonstrate the PO's oversight of dietary services by a licensed staff member, preferably a full-time Registered Dietitian be employed by the PO, and 5)all other actions deemed necessary to achieve compliance.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA	Audit Findings	8/15/2008	Open	Section 1 - Clinical PACE Elements		The PACE organization (PO) is required to: 1. submit procedures to identify, investigate, control and prevent infections in the center and in the participant's home 2. submit procedures to record any incidents of infection 3. submit procedures to analyze the incidents of infection to identify trends and develop corrective actions related to the reduction of future incidents 4. establish internal controls to include all other actions deemed necessary to achieve compliance. 5. submit to CMS Dallas Regional Office, on a monthly basis, infection control logs including trending and proposed corrective actions related to the reduction of future incidents.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA	Audit Findings	8/15/2008	Open	Section 1 - Clinical PACE Elements		The PO must revise and effectuate an effective, data-driven QAPI plan to ensure compliance with 42 CFR 460.136. The CAP must clearly describe the outcome measures that are derived from collected data to include methods of trending and analysis of data, ensures outcome measures are based on current professional practice standards with appropriate discipline oversight by licensed professionals, sets priorities for current year or quarter, prioritizes performance improvement, considering prevalence and severity of identified problems, and which gives priority to improvement activities that affect clinical outcomes. The CAP must include all other actions necessary to achieve compliance.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA	Audit Findings	8/15/2008	Open	Section 1 - Clinical PACE Elements		The PO must establish and implement a written plan to furnish care that meets the needs of each participant in all care settings 24 hours a day, every day of the year, inclusive of comprehensive medical, health, and social services that integrate acute and long-term care to ensure compliance with 42CFR 460.98. The CAP must clearly describe the measures that the PO will undertake to ensure a comprehensive coordination of care for all participants in all care settings, specifically in the LTC setting. The CAP must include all other actions deemed necessary to achieve compliance.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA	Audit Findings	8/15/2008	Open	Section 1 - Clinical PACE Elements		The CAP must clearly describe measures and written internal procedures and controls that the PO will undertake to ensure compliance with 42 CFR 460.102(b) and 460.102(d)(3) to ensure the IDT composition to be inclusive of all disciplines as required by regulation and IDT members are serving primarily PACE participants. The CAP must include all other actions deemed necessary to achieve compliance.	Open

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Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA	Audit Findings	8/15/2008	Open	Section 1 - Clinical PACE Elements		The PO must revise and effectuate written PO policy and audit internal procedures and controls to ensure compliance with 42 CFR 460.104(d)(1). The CAP must clearly describe the measures that the PO will undertake to ensure that unscheduled reassessments as required by a change in participant status be conducted by IDT members--primary care physician, registered nurse, master's-level social worker, physical therapist, occupational therapist, recreational therapist, dietitian, home care coordinator and any other necessary IDT members--in an in-person reassessment. The CAP must include all other actions deemed necessary to achieve compliance.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA	Audit Findings	8/15/2008	Open	Section 1 - Clinical PACE Elements		The PO must revise and effectuate written policy with internal audit procedures and controls to ensure compliance to 42 CFR 640.106(c)(1), (e), and (f). The CAP must clearly describe the measures that the PO will undertake to ensure that the plan of care is implemented and monitored in collaboration with the participant or caregiver and properly documented in the medical record. The CAP must include all other actions deemed necessary to achieve compliance.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA	Audit Findings	8/15/2008	Open	Section 2A-Administrative: PACE Elements		The PO must revise and effectuate an effective grievance process and internal controls to ensure compliance with 42 CFR 460.120(e). The CAP must clearly demonstrate the participants acknowledgement of the grievance process and timeframes for response at the onset of the grievance process. The CAP must include all other actions deemed necessary to achieve compliance.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA-PD	Audit Findings	8/15/2008	Open	Chapter 09: Coordination of Benefits/True Out of Pocket Costs		The Basics at Jan Werner must provide documentation that demonstrates it collects and updates information from enrollees about their OHI, including prescription drug coverage, within 30 days of enrollment and at least once annually.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA-PD	Audit Findings	8/15/2008	Open	Chapter 09: Coordination of Benefits/True Out of Pocket Costs		The Basics at Jan Werner must send the notice of the beneficiary's gross covered drug spend and TrOOP balance as of the effective date of a mid-year disenrollment to the new plan of record.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA-PD	Audit Findings	8/15/2008	Open	Chapter 10: Compliance Plan		The Basics at Jan Werner must ensure that it implements an effective internal monitoring and auditing program. The Basics at Jan Werner must develop a monitoring and auditing work plan to monitor and audit the staff and provide documentation demonstrating this to CMS. Examples of acceptable documentation include: internal auditing tools, procedures, and audit reports, as well as an auditing and monitoring work plan. The Basics at Jan Werner must revise its Compliance Plan for Medicare Part D regarding internal monitoring and auditing, including, if applicable, monitoring and auditing of subcontractors (The Basics at Jan Werner Fraud, Waste and Abuse and Compliance Program for Medicare Part D). Specifically, the 'may' on page 5, IV, A. 1, second sentence, must be changed to 'will'. Additionally, The Basics at Jan Werner must ensure that the individual designated as the Compliance Officer carries out the duties stipulated in its Fraud, Waste and Abuse and Compliance Program for Medicare Part D.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA-PD	Audit Findings	8/15/2008	Open	Chapter 10: Compliance Plan		The Basics at Jan Werner must develop a work plan, internal auditing tools and procedures for the implementation of its Fraud, Waste and Abuse plan in order to detect, correct and prevent fraud, waste and abuse. The Basics at Jan Werner must provide documentation demonstrating this to CMS. Examples of acceptable documentation include: internal auditing tools, procedures, and reports, an auditing and monitoring work plan, compliance reporting and tracking log, responses to detected offenses and correction plans, and training and education materials.	Open

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Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA-PD	Audit Findings	8/15/2008	Open	Chapter 12: Claims Processing and Payment		The Basics at Jan Werner must ensure that enrollment and payment data relating to CMS payment are mailed timely and provide documentation demonstrating this to CMS.	Open
Amarillo Multisvc Ctr Fr the Aging Inc	1-806-374-5516	H4517	MA-PD	Audit Findings	8/15/2008	Open	Chapter 15: Policies and Procedures		The Basics at Jan Werner must revise its policies and procedures to include provisions as identified in the Recommendation/Notes section for elements ER13, PA01, PA03, and CL04. No Corrective Action is required for element PR02, as the policy submitted with a date outside the audit period did contain the required provision. The Corrective Action for element CB03 contains a required modification to the policy and procedure, as well as a separate recommended modification. The changes contained in the Recommendation/Notes of this report for elements CB01, CL03, and PA02 are not required but highly suggested.	Open
Independence Blue Cross	1-215-241-3648	S4496	Part D	Ad-Hoc Compliance Event	8/11/2008	Open	Chapter 99: Ad Hoc Compliance Event		(summary) CMS requests that the organizatoin engage an outside audit organization of its own choice to assess the sponsor's ability to comply with Part D program enrollment requirements.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must provide documentation that notices were sent to members and that they were timely. The MAO must provide training to its staff and put in place processes to ensure that notices are sent and that documentation is readily available to CMS. The MAO must submit training materials and attendance log to CMS. The training must be completed and by the end of September 2008. The MAO must provide explanation for the application that did not have a signature (refer to ER01).	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must provide documentation that notices were sent to members and that they were timely. The MAO must provide training to its staff and put in place processes to ensure that notices are sent and that documentation is readily available to CMS. The MAO must submit training mateials and attendance logs to CMS. The training must bee completed by September 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must be able to provide documentation that all CMS' requirements being met. The MAO must provide training to its staff and put in place processes to ensure that documentation is maintained and is readily available to CMS. The MAO must submit training materials and an attendance log to CMS. The training must be completed by September 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must be able provide documentation to CMS when requested. The MAO must provide training to its staff and put in place processes to ensure that documentation is maintained and readily available to CMS. The MAO must provide training matial and attendance logs to CMS. The training must be completed by the end of September 2008.	Open

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MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		MD Medicare Choice must submit supporting documentation to show the elections were completed by the beneficiaries and or representatives, authorized under laws of the state, or other media that supports an election for cases 12, 26 and 29. MD Medicare Choice must conduct an audit of all telephonic enrollments completed during the review period and provide evidence that these enrollment elections were completed at the request of the beneficiaries enrolled. The evidence must include all of the requirements specified in Chapter 2 of the Medicare Managed Care Manual. MD Medicare Choice must adhere to its own policy and procedure EN 10.6 and ensure all applications are complete prior to submission to CMS as outlined in Medicare Managed Manual Chapter 2 and 42 CFR 422.60c.1. MD Medicare Choice must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals trained. This information must be submitted to CMS reviewer by September 30, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		MD Medicare Choice must ahere to its own policies and procedures (EN10.16, EN10.17, EN10.18, and EN10.21) and ensure applications are processed with the correct effective dates during the applicable election period. MD Medicare Choice must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MD Medicare Choice must conduct a monthly audit of their enrollment process for three months beginning September 1, 2008 through November 30, 2008 and provide a monthly report to the CMS Regional Office to include the following information: a. Copies of all applications received for the period September 1, 2008 through November 30, 2008. b. Provide supporting documentation if a POA is identified. c. Enrollment period used d. Effective date of enrollment.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		1) MD Medicare Choice must revise its policies and procedures for identifying incomplete enrollment elections and requesting additional information to complete elections. 2) MD Medicare Choice must conduct training of appropriate staff on these policiesand procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training to include the policies and procedures, the individuals conducting the training, and the individuals being trained. This information must be provided to the CMS reviewer by September 30, 2008.	Open

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MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		MD Medicare Choice must revise its policies and procedures to ensure beneficiaries receive appropriate notices within the required timeframes specified by CMS. Policies and procedures must be revised to include the following: 1) Revise its policy and procedures to ensure notices are processed within the specified timeframes outlined in the Medicare Managed Care Manual Chapter 2 Enrollment and Disenrollment and in accordance with CMS guidelines and 42 C.F.R., section 422.60e.3. 2) MD Medicare Choice must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to the CMS reviewer by September 30, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		MD Medicare Choice must revise its policies and procedures to ensure beneficiaries receive the correct information according to CMS regulations and guidelines. Policies and procedures must be revised to include the following: 1) Revise its policy and procedures to ensure notices include the correct information in accordance with CMS regulations and guidelines and the Medicare Managed Care Manual Chapter 2 Enrollment and Disenrollment sections Section 40.4, 40.4.2, and in accordance with 42 C.F.R., section 422.60e,3. 2) MD Medicare Choice must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to the CMS reviewer by September 30, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must provide training to its staff and put in place processes to ensure that notices are sent to members timely. The MAO must provide training to its staff. The MAO must provide CMS with the training materials and attendance log. The MAO must complete this training by the end of September 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 02 - Enrollment and Disenrollment		MD Medicare Choice must develop a policy and procedure for all CMS enrollment or disenrollment rejections identified on the transaction reply report to include the appropriate action that must be taken in all instances. MD Medicare Choice must submit the policy and procedure to CMS for review and approval. Once approved, MD Medicare Choice must implement the procedure and provide training to appropriate staff. MD Medicare Choice must submit to CMS the training outline, the staff attending the staff, and the training date.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 03 - Marketing		The MAO must provide to CMS the enrollments for each sales agent/broker in the sample. The MAO must ensure that all state licensure requirements are met for its sales agents/brokers. The MAO must establish processes to ensure that they are submitting timely requests for appointments to the state. The MAO must provide CMS with a bi-weekly report on the status of all existing sales agent/broker appointments. The MAO must report to CMS, on monthly basis, when a sales agent/broker has been hired and appointment requested. The MAO will continue this reporting until CMS determines it is no longer necessary.	Open

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MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 06 - Provider Relations		Medicare Choice must adhere to its own policies and procedures and ensure all providers are properly credentialed. MD Medicare Choice must audit provider files all 5,065 and send CMS a detailed report on its progress. The report must contain all of the CMS required elements contain in Chapter 6 of the Medicare Managed Care Manual section 60.3. Once the audit is complete, MD Medicare Choice must send CMS Regional Office updated HSD tables listing all providers within its network that are contracted, credentialed and are providing services to its members	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 11 - Contracts		MD Medicare Choice must audit all of its contracts to ensure they contain all of the contract provisions specified in Chapter 11, section 100.4 of the Managed Care Manual. MD Medicare Choice must conduct an audit of its contracts and ensure a valid contract exists for all providers listed in their provider directory. MD Medicare Choice must remove providers from their directory if a valid contract is not located. After completion of the audit, a report must be submitted to CMS that shows a contract exists for each provider listed in your directory. This report is due to CMS Atlanta Regional Office by September 30, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 11 - Contracts		Refer to CN02.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 11 - Contracts		Refer to CN02.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 11 - Contracts		Refer to CN02.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must conduct training of appropriate staff on their policy and procedure (MDMC-GA-13.004) and submit documentation to CMS that details the nature of the training, the materials used in the training, the individuals conducting the training, and the individuals being trained. MD Medicare Choice must audit all 42 grievances listed in the universe to ensure they are correctly categorized. Cases involving claims payment or service denials must be processed as an appeal as outlined in Chapter 13 of the Medicare Managed Care Manual. Cases must not be denied for not meeting the 60 day timeframe. Cases that are unfavorable to the member must be forwarded to the independent review entity for review. A detailed report of the audit must be sent to the CMS Regional Office. The report must include the denial, reason for the denial and the date the case was forwarded to the independent review entity. The report must include the date the claim was paid or the service provided in cases that are favorable to the member. MD Medicare Choice must perform a quarterly audit of all grievances received and provide a report to the CMS Regional Office the disposition of the grievances.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must adhere to its own policy and procedure (MDMC-GA-13.003) and provide acknowledgement of grievance within 7 days, and send notification of results to all parties within 30 calendar days from the date the grievance is filed. MD Medicare Choice must conduct training of appropriate staff regarding their policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must follow to its own policy and procedure (MDMC-GA-13.003) and inform members of the grievance disposition. MDMC must audit the 42 grievances contained in the universe, and provide the grievance resolution to members in all instances where this was not done. MDMC must submit a report to the CMS Regional Office when this is accomplished. The report should include, the date the audit was done, the number of members affect, the number of resolution letters sent, and the date the letters were sent. MD Medicare Choice must conduct training of appropriate staff on their policy and procedure (MDMC-GA-13.003) and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must follow its own policy and procedure (MDMC-GA-13.003) and inform members (both written and oral) of the grievance disposition. MDMC must audit the 42 grievances contained in the universe, and provide the grievance resolution to members in all instances where this was not done. MDMC must submit a report to the CMS Regional Office when this is accomplished. The report should include, the date the audit was done, the number of members affected, the number of resolution letters sent, and the date the letters were sent. MD Medicare Choice must conduct training of appropriate staff on its policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		1) MD Medicare Choice must develop and implement policies and procedures that clearly describe the steps for properly denying a claim. 2) MD Medicare Choice must revise its current claims process to ensure claims are being developed for additional information. 3) MD Medicare Choice must develop a system for distinguishing contracted providers from non contracted providers. 4) MD Medicare Choice must develop a system for processing claims within CMS timeframes in accordance with 42 C.F.R., 422.100 a and b, 1, 422.132, 422.504 g 1 and Medicare Managed Care Ch. 4 Manual, section 10.2. 5) MD Medicare Choice must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be provided to the CMS reviewer by September 15, 2008. 6) MD Medicare Choice must conduct an audit of their delegated claims provider within 30 days of receiving this report. The audit will be conducted for the period July through August 2008 on all denied claims. Provide a copy of the report to the CMS reviewer by September 30, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must monitor its claims payment processes to ensure that all clean claims are processed within the required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and results of the audits must be provided to CMS on a quarterly basis until further notice. The first report must be submitted to CMS by September 30, 2008.	Open

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MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must put into place processes to ensure that the interest is paid on claims and the correct amount of interest is paid. The MAO must provide CMS with policies and processes outlining these processes. The MAO must incorporate in these policies and procedures the process for mailing of checks on date issued.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		1) MD Medicare Choice must develop and implement policies and procedures that clearly describe the steps for properly adjudicating a claim. 2) MD Medicare Choice must revise its current claims process to ensure claims are being processed within CMS specified timeframes and in accordance with 42 C.F.R., 422.520 a, 3 and Medicare Managed Care Ch. 11 Manual sections 100.2 and Medicare Managed Care Ch. 13 Manual section 40.1 3) MD Medicare Choice must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be provided to the CMS reviewer by September 15, 2008. 4) MD Medicare Choice must conduct an audit of their delegated claims provider within 30 days of receiving this report. The audit will be conducted for the period July through August 2008 on denied claims. Provide a copy of the report to the CMS reviewer by September 30, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		1) MD Medicare Choice must develop and implement policies and procedures that clearly describe the steps for including the appropriate information in the notices for denied claims. 2) MD Medicare Choice must revise its current claims process to ensure notices include the correct denial code and reason for denial. 3) MD Medicare Choice must develop a system for ensuring compliance in accordance with 42 C.F.R., section 422.568d and e, and Medicare Managed Care Ch. 13 Manual section 40.2.2. 4) MD Medicare Choice must conduct training of appropriate staff on these policies\and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be provided to the CMS reviewer by September 15, 2008. 5) MD Medicare Choice must provide a copy of the CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP CMS notice to the CMS reviewer by September 1, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must follow its own policy and procedure and ensure that denial of services notices are sent timely. MD Medicare Choice must provide training on these procedures to appropriate staff. MD Medicare Choice must sent to the CMS Regional Office, the date of the training, the materials used, and the staff trained.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must revised the standard denial letter language contained in MDMC-UM-602C. The standard denial language is vague and does not provide the specific denial reason. MD Medicare Choice must provide training on these procedures to appropriate staff. MD Medicare Choice must send to the CMS Regional Office, the date of the training, the materials used, and the staff trained.	Open

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MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must follow its own policy and procedure and ensure favorable standard preservice determinations are appropriately documented and the documentation is easily retrievable. MD Medicare Choice must provide training on these procedures to appropriate staff. MD Medicare Choice must sent to the CMS Regional Office, the date of the training, the materials used, and the staff trained.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must adhere to its own policy and procedure MDMC-GA-13.004 concerning the steps taken when an initial decision is overturned. MD Medicare Choice must conduct training on this procedure to appropriate staff and notify CMS Regional Office when this is accomplished. Training is toinclude, the date of the training, materials used, and staff trained. MD Medicare Choice must conduct an audit of the 78 cases contained in the universe and ensure members are notified of the decision and the claim is paid. MD Medicare Choice must send a report to CMS regional office when this is completed. The report should include the member's name, type of service denied, date member was notified, and the date the claim was paid. This should be accomplished by September 30, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must adhere to their own policy and procedure (MDMC-GA-13.004) concerning the steps taken when an initial decision is overturned. MD Medicare Choice must conduct training on this procedure to appropriate staff and notify CMS Regional Office when this is accomplished. This is to include, the date of the training, materials used, and staff trained. MD Medicare Choice must research this case and forwarded the information to the Independent Review Entity for reconsideration and notify CMS regional office when this is accomplished but no later than September 30, 2008.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must adhere to its own policy and procedure MDMC-GA-13.005 and ensure cases are effectuated when an overturn is received from the Independent Review Entity (IRE). If the decision received from the IRE is overturned, MD Medicare Choice must ensure the decision is effectuated and notify CMS regional office when this occurs. MD Medicare Choice must provide training on these procedures to appropriate staff. A report must be sent to the CMS Regional Office once the training is completed, which includes the date of the training, the materials used, and the staff trained.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must adhere to its own policy and procedure (MDMC-GA-13.004) and ensure cases are forwarded to the the Independent Review Entity (IRE)when the reconsidered decision is not fully favorable to the member. MD Medicare Choice must forward this case to the IRE and notify the member and CMS regional office when this is accomplished. MD Medicare Choice must provide training on these procedures to appropriate staff. A report must be sent to the CMS Regional Office once the training is completed, which includes the date of the training, the materials used, and the staff trained	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA	Audit Findings	8/11/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		MD Medicare Choice must adhere to its own policy and procedure (MDMC-GA-13.005) and ensure cases are effectuated when an overturn is received from the Independent Review Entity (IRE). If the decision received from the IRE is overturned, MD Medicare Choice must ensure the decision is effectuated and notify CMS regional office when this occurs. MD Medicare Choice must provide training on these procedures to appropriate staff. A report must be sent to the CMS Regional Office once the training is completed, which includes the date of the training, the materials used, and the staff trained	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA-PD	Audit Findings	8/11/2008	Open	Chapter 01: Enrollment and Disenrollment		Some reviewed samples included dates the confirmation from the member for continued enrollment in the plan, was prior to the date the plan received notification of their existing enrollment from CMS. MD Medicare Choice must provide CMS with a written explanation of how this occurred. MD Medicare choice must also revise its policies and procedures to include retaining a record of the beneficiary confirmation, whether written or verbal, with the record of the individual's enrollment request. MD Medicare Choice must send a denial notice to the beneficiary if the beneficiary does not respond within 30 calendar days from the date he/she is contacted, or indicates s/he does not wish to enroll. MD Medicare Choice must conduct training of appropriate staff on retaining a record of beneficiary confirmation, whether written or verbal with the record of the individual's enrollment request. This training must also include sending a denial notice to the beneficiary if the beneficiary does not respond within 30 calendar days from the date he/she is contacted, or indicates s/he does not wish to enroll. MD Medicare Choice must submit documentation to CMS detailing the nature of the training, the individuals being trained, and the individuals conducting the training.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA-PD	Audit Findings	8/11/2008	Open	Chapter 02: Provider Communication		MD Medicare Choice must devise a policy and procedure to address Provision of Notice Regarding Formulary Changes. This policy must include sections addressing how the Part D sponsor will provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary, making any negative changes to utilization management, or making negative changes to the preferred or tiered cost sharing status of a covered Part D drug.	Open
MD MedicareChoice, Inc.	1-813-425-0921	H5729	MA-PD	Audit Findings	8/11/2008	Open	Chapter 03: Marketing and Beneficiary Information		MD Medicare Choice needs to provide CMS with an explanation of why 4 of the 10 samples reviewed did not contain an Explanation of Benefits. MD Medicare Choice needs to provide CMS with updated policies and procedures that address when members should receive an Explanation of Benefits for their Part D medications. MD Medicare Choice should provide CMS with a model EOB notice that is used when a negative formulary change is made. The notice should be compliant with Model 10 from Chapter 18 of the Prescription Drug Benefit Manual. MD Medicare choice must then submit this notice for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. MD Medicare choice must provide evidence that it's Prescription Benefits Manager, MedImpact Healthcare Systems, Inc., has conducted training on the EOB notice, the nature of this training, the materials used in the training, individuals conducting the training and individuals being trained.	Open

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EmblemHealth Inc.	1-518-446-6941	H4729	MA-PD	Ad-Hoc Compliance Event	8/4/2008	Open	Chapter 99: Ad Hoc Compliance Event		In response to this CAP request, CMS asks that your organization submit the following to CMS: - Updated policies and procedures explaining how your organization will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2009 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission as well as a plan describing how your organization will be prepared to accommodate the quick tum-around times for future formulary submissions. - A discussion of the steps your organization will take to ensure it can meet the requirements for the CY201 0 formulary review process. This portion of the CAP should describe any arrangements your organization has made to ensure that it maintains adequate oversight and control over any organizations or individuals contracted with to provide formulary services on your organization' s behalf. - A plan for how your organization will ensure that the CY2009 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. CMS recognizes that your organization is affiliated with other sponsors that will receive a CAP request that mirrors this one. The sponsors may individually submit CAPs to CMS or they may submit one CAP that reflects the actions that sponsors will undertake. If a single CAP is submitted for several sponsors, a page ofthe CAP must include (a) language indicating that all sponsors signing the CAP will undertake the actions outlined in the submission and (b) signature of the sponsor's CEO, compliance officer, or both. CMS requests your organization submit the CAP by Wednesday, August 27,2008 at 5:00 p.m. In the event your organization does not successfully satisfy its CAP, CMS will consider additional compliance actions, including the imposition of intermediate sanctions. CMS also notes that your organization's failure to meet the Part D formulary submission and approval requirements during CY2009 may result in CMS electing not to renew your organization's MA-PD contract for CY201O.	Open
Independence Blue Cross	1-215-241-3648	S2770	Part D	Ad-Hoc Compliance Event	8/4/2008	Closed	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	CMS requests your organization to submit to CMS a CAP containing a discussion of how your organization resolved the discrepancies as well as the policies and procedures that describe how your organization will prevent formulary adjudication and formulary marketing material errors in the future.	Closed

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Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 1 - Clinical PACE Elements		The Center must facilitate the assessment process between the dietician and restorative rehabilitative staff for the integration of dietary care needs into the care plan. These include but not limited to Nutritional Review, Physical or functional changes, Gastroenterological symptoms, Gustatory symptoms, Dietary intake and Laboratory values. Refer to CAR under SDY04. The Center will have a dietician in the common area supervising the process with every meal. Provide an implementation timeline to CMS and the New York State Department of Health. The Center will obtain resources to adequately serve and plate the food received from the contractor within a reasonable timeframe to maintain temperatures as well as serve all participants in the following areas: Kitchen, Common/Dining Area, Comfort Zone and Rehabilitative Area. ILS needs to indicate how they will ensure that participants needing assistance with feeding will receive this assistance in a timely manner, including non-English speaking participants. Provide a plan as to how ILS will address these issues, including a timeline for implementation and the personnel responsible for implementation, to CMS and the New York State Department of Health. ILS needs to indicate how they will ensure that participants with special dietary needs will receive a nutritionally balanced meal and indicate how they will ensure that participants and not family or other participants are not consuming all or part of a participant meal. ILS needs to submit its plan to CMS and the New York State Department of Health.	Open
Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 1 - Clinical PACE Elements			Open
Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 1 - Clinical PACE Elements		ILS needs to revise the criteria for day care attendance that meets the physical, medical, psychological and social needs of participants and submit the revised criteria to CMS and the New York State Department of Health for review and approval. ILS must develop a plan to reassess all participants to assure that needed services are provided, such as adaptive equipment. Participants whose day care attendance has been reduced are also to be reassesed based on the amended criteria once it has been approved, to determine whether the reduction of day center services is warranted based on participant needs. In addition, ILS needs to develop criteria for triaging the assessments based on risk and condition. Provide CMS and the New York State Department of Health with a timeline indicating when these assessments will be accomplished for review and approval.	Open
Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 1 - Clinical PACE Elements		ILS needs to develop a plan by which required compliment of IDT members attend Care Plan meetings and other IDT functions and a timeline for implementation. Submit a copy of the plan and timeline to CMS and the New York State Department of Health for Review ands approval.	Open
Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 1 - Clinical PACE Elements		ILS needs to revise the criteria for day care attendance and reassess participants whose day care attendance has been reduced based on the revised criteria to determine whether the reduction of day center services is warranted based on participant needs. Include a timeline for completion. ILS must develop a process to ensure that any decision to reduce services is based on an assessment and that full explanation of the reason for the reduction is provided in easily understood language to the participant and/or his/her representative.	Open

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Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 1 - Clinical PACE Elements		ILS must develop a comprehensive care plan that that incorporates all of the required PACE elements and identifies care needs and problems specific to each discipline involved in the care of the participant, the care to be provided, objective, obtainable goals, the individual responsible and outcomes. Care plans need to reflect changes in status, care needs and goals. There needs to be documentation of participant or caregiver input into the plan of care. A copy of the care plan needs to be provided to CMS and to the New York State Department of Health for review and approval prior to implementation. Once the revised Care Plan has been reviewed and approved, provide a timeline and the personnel responsible for implementation. ILS must develop a plan that will ensure that all nursing staff administers medications in a safe and effective manner. The plan needs to include staff education as well as a medication assistance record that is accurate and complete to specific route, time and dosage and a method of monitoring to ensure that all nursing staff are supervised on a regular basis to ensure compliance. Provide a timeline and the personnel responsible for implemntation. Submit a copy of the plan, including the training module and staff attendance rosters to CMS and the New York State Department of Health.	Open
Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 1 - Clinical PACE Elements		Refer to SDY05, Plan of Care.	Open
Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 2A-Administrative: PACE Elements		ILS must document how its governing body will take a more active role in the oversight of the PACE. A statement co-signed by the Chairman of ViaHealth and the President of ILS must be submitted, attesting to their agreement that the ILS board will retain oversight of the PACE and such oversight shall be reflected in the board minutes. Submit the minutes of the next two Board of Directors meetings.	Open
Rochester General Hospital	1-585-922-2825	H3331	MA	Audit Findings	8/1/2008	Open	Section 3 - Ad Hoc Compliance Events		ILS needs to develop a plan to ensure that participants are afforded privacy and confidentiality in their care and treatment, including a plan to train all staff.	Open

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Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing	The Cost plan does not engage in activities which materially mislead, confuse, or misrepresent the Cost plan and: -May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; -May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; -May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all Cost plan involved and unless the materials have received prior approval from CMS; -May not accept plan applications in provider offices or other places where health care is delivered; -May not employ Cost plan plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); -May not offer gifts or payment as an inducement to enroll in the organization; -May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and -May not conduct door-to-door solicitation of Medicare beneficiaries.	Policies and Procedures Medica must develop and implement policies and procedures that test the understanding of the Medicare program by all individuals who sell Cost Plans. The policies and procedures must also explain the consequence of an individual's inability to pass the test. Submit these policies and procedures and the test to the regional office. Training Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Develop Oversight Medica must establish and maintain effective oversight controls of all individuals who sell Cost Plans to ensure they understand the Medica program specifically Cost plans. Submit these policies and procedures which describes the types of oversight activities it will implement over all individuals who sell Cost Plans to the regional office. Audits Medica should submit a summary report once a month to the regional office of its progress towards developing a test for all individuals who sell Cost plans until the test has been completed. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.	Open
Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan disenrolls Medicare members, when appropriate, upon receipt of a request for disenrollment. The Cost plan annotates its own system and the CMS system with the correct disenrollment effective date.	Training Medica must conduct training of appropriate staff on determining the appropriate date of disenrollment for it's members. Submit documentation of the training to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Improve Oversight Medica must revise its oversight procedures to ensure that the appropriate date of disenrollment is correct. Submit revised oversight procedures to the regional office. Policies and Procedures Policies and procedures must be revised to reflect these improvements. Medica must submit the revised poilicies and procedures which describe the oversight activities. Audits Medica should conduct an internal audit each month on the appropriate disenrollment date for members who are to be disenrolled. This audit should evaluate whether the disenrollment date for members is correct. Medica should submit a summary report once a quarter to the regional office of its monthly findings until further notified. The summary report should include: title of auditor(s), the audit methodology, and the results of the audit.	Open

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Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan may involuntarily disenroll Medicare members who fail to pay premiums. The Cost plan must send a written notice of nonpayment to the member and allow the member at least 20 days from the date of the notice to pay in full. If the member does not pay in full within the 20 days allowed, the Cost plan may disenroll the member as of the last day of the month following the expiration of the 20 days.	Policies and Procedures Medica must develop and implement policies and procedures that address the process to follow to involuntary disenroll members for non-payment of premium. Medica must conduct training of appropriate staff these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Develop oversight Medica must establish and maintain effective oversight controls over its delegated entities to ensure that beneficiaries are not involuntary disenrolled for non-payment of premiums. The MCO must submit a policy and procedure which describes the types of oversight activities it will implement over its delegated entities.	Open
Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan must disenroll Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than 90 days. Member notice is required prior to transmission of the disenrollment to CMS. (exception: cost plans may retain members under the extended absence rule. Extended absence is when a member leaves the service area for more than 90 days, but returns within one-year.)	Training Medica must conduct training of appropriate staff on the correct timeframes the move-out-of service area notice of disenrollment must be sent to it's members. Submit documentation of the training to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Improve Oversight Medica must revise its oversight by ensuring that the proper move out-of-service procedure is followed. Submit revised oversight procedures to the regional office. Policies and Procedures Policies and procedures must be revised to reflect these improvements. Medica must submit the revised poilicies and procedures which describe the oversight activities. Audits Medica should conduct an internal audit each month on the appropriate date of disenrollment when members permanently leave the approved plan service area or who resided outside the approved plan service area for more than 90-days. This audit should evaluate whether the move out-of-service area disenrollment date for members is correct. Medica should submit a summary report once a quarter to the regional office of its monthly findings until further notified. The summary report should include: title of auditor(s), the audit methodology, and the results of the audit.	Open
Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan correctly submits requests to the CMS Central Office for retroactive disenrollments in instances where, due to CMS error, there was never a legally valid enrollment or a valid request for disenrollment was properly made but not processed or acted upon. Supporting information is included in accordance with CMS policy.	Policies and Procedures Medica must revise its policies and procedures to outline the process they follow for retroactive disenrollments for members in instances where, due to CMS error, there was never a legally valid enrollment or valid request for disenrollment was properly made but not processed or acted upon. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Develop oversight Medica must establish and maintain effective oversight controls over its delegated entities to ensure that retroactive disenrollments due to CMS error are correctly processed. The MCO must submit a policy and procedure which describes the types of oversight activities it will implement over its delegated entities.	Open

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Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan may disenroll Medicare members for disruptive behavior only when their behavior is disruptive, unruly, abusive, or uncooperative to the extent that continuing membership seriously impairs the Cost plan's ability to furnish services to the member or other members. Disruptive behavior includes threats of violence by the member to employees of the Cost plan. The Cost plan disenrolls Medicare members for disruptive behavior only after serious efforts to resolve the problem, including the use of internal grievance procedures, consideration of extenuating circumstances, and CMS' advance approval of the proposed disenrollment, have been made. The Cost plan disenrolls members effective the first day of the calendar month after the month in which notice is sent to the members of the intended action.	Policies and Procedures Medica must revise its policies and procedures to outline the process they follow to involuntary disenroll a member for disruptive behavior only when their behavior is disruptive, unruly, abusive, or uncooperative to the extent that continuing membership seriously impairs the Cost plan¿s ability to furnish services to the member or other members. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Develop oversight Medica must establish and maintain effective oversight controls over its delegated entities to ensure that beneficiaries are correctly involuntary disenrolled due to distruptive behavior. The MCO must submit a policy and procedure which describes the types of oversight activities it will implement over its delegated entities.	Open
Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan may disenroll Medicare members when they commit fraud or permit abuse of their enrollment cards. Fraud is limited to knowingly providing, on the election form, fraudulent information that materially affects the members' eligibility to enroll in a Cost plan. Abuse of members' enrollment cards includes intentionally permitting others to use their enrollment cards to obtain services under the Cost plan. The Cost plan disenrolls Medicare members for fraud or abuse only after the Cost plan mails the members a written notice that includes an explanation of the members' right to a hearing under the Cost plan's grievance procedures. The Cost plan disenrolls members effective the first day of the calendar month after the month in which notice is sent to the members of the intended action.	Policies and Procedures Medica must revise its policies and procedures to outline the process they follow to disenroll beneficiaries who commit fraud or permit abuse of their enrollment cards. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Develop oversight Medica must establish and maintain effective oversight controls over its delegated entities to ensure that beneficiaries who commit fraud or permit abuse of their enrollment cards are correctly disenrolled. The MCO must submit a policy and procedure which describes the types of oversight activities it will implement over its delegated entities.	Open
Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan must correctly identify incomplete enrollment forms and follow CMS requirements for requesting information from the beneficiaries to make the forms complete.	Corrective Action Plan Policies and Procedures Medica must revise its policies and procedures to outline the process they follow when the correct enrollment election type is not accepted by CMS. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Develop oversight Medica must establish and maintain effective oversight controls over its delegated entities to ensure that the correct enrollment election type is the correct enrollment election type on the member¿s application and in CMS¿s system. The MCO must submit a policy and procedure which describes the types of oversight activities it will implement	Open

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Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	Training Medica must conduct training of appropriate staff on the correct process to follow on the denial of enrollment prior to transmission to CMS. Submit documentation of the training to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Improve Oversight Medica must revise its oversight to ensure that the denial notice is sent within the timeframes specified by CMS. Submit revised oversight procedures to the regional office. Policies and Procedures Policies and procedures must be revised to reflect these improvements. Medica must submit the revised poilicies and procedures which describe the oversight activities. Audits Medica should conduct an internal audit each month on whether the correct process was followed on the denial notice prior to transmission to CMS. This audit should evaluate whether the disenrollment date for its members is correct. Medica should submit a summary report once a quarter to the regional office of its monthly findings until further notified. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.	Open
Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Chapter 17, Subpart D - Enrollment and Disenrollment	When the Cost plan receives information from CMS, it promptly, within timeframes specified by CMS, notifies beneficiaries in writing of CMS' acceptance of enrollment.	Training Medica must conduct training of appropriate staff on the correct timeframes the final notice of enrollment must be sent to it's members. Submit documentation of the training to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Improve Oversight Medica must revise its oversight to ensure that the final notice of enrollment follows CMS timeframes. Submit revised oversight procedures to the regional office. Policies and Procedures Policies and procedures must be revised to reflect these improvements. Medica must submit the revised poilicies and procedures which describe the oversight activities. Audits Medica should conduct an internal audit each month on the correct timeframes the final notice of enrollment must be sent to it's members. This audit should evaluate whether the disenrollment date for members who were disenrolled is correct. Medica should submit a summary report once a quarter to the regional office of its monthly findings until further notified. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.	Open

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Medica Health Plans	1-952-992-2315	H2450	MA	Audit Findings	7/31/2008	Open	Organization Determinations, Grievances, and Appeals - Organization Determinations - Claims		Training Medica must conduct training of appropriate staff on including a complete denial reason in member notices and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Policies and Procedures The policies and procedures must be updated to reflect these improvements. Medica must submit the revised policies and procedures to the regional office. Audits Medica should conduct an internal audit each month to ensure the notice states the specific reasons for the determination. This audit should evaluate whether the language used for the denial reason fully describes the reason the reason the service was denied. Medica should submit a summary report once a quarter to the regional office of its monthly findings until further notified. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.	Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 11 - Contracts			Open

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Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals			Open
Medica Health Plans	1-952-992-2315	H2409	MA	Audit Findings	7/31/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals			Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must ensure that it has a process to send disenrollment acknowledgment letter within 10 calendar days of receipt of the request to disenroll. Medica must establish a mechanism for ongoing monitoring of this area to ensure compliance.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must revise its voluntary disenrollment notices to reflect disenrollment effective the first day of the month following the disenrollment request as well as revise its policies and procedures to reflect this requirement.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must develop and implement policies and procedures which prevents the plan from disenrolling beneficiaries for nonpayment of premiums in cases where the beneficiary has selected to have their premiums deducted from their Social Security Check or when the plan has been notified that a State Pharmaceutical Assistance Program (SPAP) or other payer intends to pay the Part D premium on behalf of an individual. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must revise its policies and procedures by eliminating the 30 day notification requirement for reinstatement of a beneficiary¿s Part D coverage. Medica must submit these policies and procedures to the regional office. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must develop and implement policies and procedures which meet the requirements of Section 50.3.2 for involuntary disenrollment for disruptive behavior. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must revise its policies and procedures to include detailed procedures for requesting CMS review of potential termination of members for fraud and abuse, and a requirement to mail the disenrollment notice to the members before submission of the disenrollment notice to CMS. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must develop and implement policies and procedures which require the eligibility type field of the enrollment form to be completed by Medica staff. Medica must develop and implement policies and procedures which require that whenever Medica receives enrollment rejections for improper enrollment type incorrectly, they must contact their account manager for assistance and open a CMS trouble ticket with the CMS help desk. In addition, Medica must develop and implement policies and procedures to determine eligibility for SEPs per section 30.4 of Chapter 2 of the Medicare Managed Care Manual, including proper documentation of this eligibility and record retention. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must ensure that it has a process to send enrollment acknowledgment letter within 10 calendar days of receipt of the completed enrollment election. Medica must ensure that it has a process to send enrollment confirmation letters within 10 calendar days of receipt of the reply listing. Medica must establish a mechanism for ongoing monitoring of this area to ensure compliance.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica should revise its policies and procedures to contact the applicant to discuss CMS requirements regarding the effective date of enrollment. If the applicant does not wish to enroll for the current effective date, Medica should document that information in its notes and send the denial letter. If the applicant wishes to enroll for the current effective date, Medica should document that information and process the enrollment application.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must revise its policies and procedures to request retroactive enrollments when appropriate and ahear to CMS requirements in the process of requesting these enrollments. Medica must conduct appropriate training of staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 02 - Enrollment and Disenrollment		Medica must develop and implement policies and procedures to require that Medica send out a working aged survey to members listed on the March Monthly Membership Report (MMR), including those who have disenrolled from the plan even if the member is no longer enrolled when the survey is conducted.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing		Medica enrollment acknowledgement and confirmation letters should be updated to reflect current model language that has been developed for PFFS plans. In addition the confirmation letter should remove the language that members must stay with the premium payment option you choose for the rest of the year. Medica denial letter should be updated to reflect current model language and to add that the customer service call center is open from 8 am to 8 pm seven days a week. Medica disenrollment acknowledgement and confirmation letters should be updated to reflect current model language that has been developed for PFFS plans. Medica should ensure that it states the correct date of disenrollment in its member notices. Further, Medica must add that the customer call center is open from 8 am to 8 pm seven days a week. Medica must submit the updated letters to CMS for review and approval.	Open

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Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing		Medica must implement policies and procedures to test the understanding of the Medicare program by all individuals who sell MAO plans. Medica must submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing		Medica enrollment acknowledgement and confirmation letters should be updated to reflect the PFFS disclaimer language. Medica must submit the updated letters to CMS for review and approval.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 03 - Marketing		Medica must revise its policies and procedures to mail a CMS-approved verification/education letter after the first unsuccessful telephone attempt. Medica must provide a copy of this updated policy to the regional office.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 11 - Contracts		Medica must develop and implement policies and procedures that contain all of the required provisions that contracting entities agree to safeguard beneficiary privacy and confidentiality, consistent with all Federal and State laws, and ensure the accuracy of beneficiary medical, health, and enrollment information and records per 42 C.F.R Section 422.118 and Manual Ch 11, Section 100.4. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of the training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Medica must revise its policies and procedures to clearly state the service denied and the specific denial reason per Chapter 13, section 40.2.3. Medica must submit this updated information to the regional office for review in understandable terms.	Open
Medica Health Plans	1-952-992-2315	H2410	MA	Audit Findings	7/31/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Medica must develop and implement policies and procedures that requires the MAO provide to plan enrollees, for each claim filed by the enrollee or the provider that furnished the service, an appropriate explaination of benefits, even when there is no beneficiary liability per 42 CFR Section 422.216(d)(1). The explanation must include a clear statement of the enrollee¿s liability for deductibles, coinsurance, copayments, and balance billing. Medica must submit this updated information to the regional office for review.	Open
Medica Health Plans	1-952-992-2315	H2450	MA-PD	Audit Findings	7/31/2008	Open	Chapter 01: Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2450	MA-PD	Audit Findings	7/31/2008	Open	Chapter 01: Enrollment and Disenrollment			Open
Medica Health Plans	1-952-992-2315	H2450	MA-PD	Audit Findings	7/31/2008	Open	Chapter 03: Marketing and Beneficiary Information			Open
Medica Health Plans	1-952-992-2315	H2410	MA-PD	Audit Findings	7/31/2008	Open	Chapter 01: Enrollment and Disenrollment		Medica must develop and implement policies and procedures that meet the above requirements per Chapter 2 of the Medicare Managed Care Manual. Medica must submit this information to the CMS regional office for review.	Open
Medica Health Plans	1-952-992-2315	H2410	MA-PD	Audit Findings	7/31/2008	Open	Chapter 01: Enrollment and Disenrollment		Medica must develop and implement policies and procedures that comply with the Medicare Managed Care Chapter 2 requirements for confirmation of enrollment for members of employer/union group receiving employer subsidy. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Medica Health Plans	1-952-992-2315	H2410	MA-PD	Audit Findings	7/31/2008	Open	Chapter 03: Marketing and Beneficiary Information		Medica must revise these enrollment letters to include a correctly formatted marketing material number and resubmit these documents to the regional office account manager through HPMS for review. Medica must develop and implement policies and procedures that require all marketing documents to comply with the marketing material number format per the CMS marketing guidelines.	Open
Medica Health Plans	1-952-992-2315	H2410	MA-PD	Audit Findings	7/31/2008	Open	Chapter 15: Policies and Procedures		Medica must develop and implement policies and procedures that comply with the requirements of the Enrollment and Disenrollment Chapter of the most current version of the Medicare Advantage Manual. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H1961	MA	Audit Findings	7/25/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MA organization must develop a corrective action plan to ensure that they are in compliance with Medicare Managed Care Manual Chapter 2, Section 40.2.2. The CAP must include a revision to the notice content and any other actions deemed necessary to demonstrate compliance.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H1961	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to ensure that its delegated entity adjudicates claims in accordance with 42 CFR 422.100(a) and (b)(1), 422.132,422.502(g)(1)and Manual Chapter 4 - Section 10.2. The corrective action plan should include training, internal auditing, correction of any policies and procedures and any other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H1961	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to ensure that non-contracted provider clean claims are processed in accordance with 42 CFR 422.500,422.520(a)(1), Manual Chapter 11 - Section 100.2 and Manual Chapter 13 - Section 40.1. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H1961	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to ensure that non-contracted provider clean claims are processed in accordance with 42 CFR 422.520(a)(3), Manual Chapter 11 - Section 100.2 and Manual Chapter 13 - Section 40.1. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H1961	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to implement the use of the standard denial notice, as provided by 42 CFR 422.568(d) and (e), and Manual Chapter 13 - Section 40.2.2. The corrective action plan must include the development and marketing submission of the standard denial notice to the Regional Office for approval as well as training concerning appropriate completion of the form. The corrective action plan must also include internal auditing, the correction of any policies and procedures and all other actions deemed necessary to demonstrate compliance.	Open

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Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H1961	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Per CMS requirements, Tenet must ensure that the correct samples are selected for this element. If a favorable organization determination is made, the member must be notified no later than 14 calendar days after receiving the request. Tenet must conduct a three month internal audit of Favorable Standarad Pre-Service Organization Determinations (Timeliness)from July 1-September 30, 2008 and submit the results to CMS no later than October 15, 2008.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H1961	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		As required by CMS, when Tenet makes a favorable standard pre-service reconsideration, the member must be notified of the decision as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). Tenet must conduct an internal audit of this element for July 1, 2008-September 30, 2008 and submit the results to CMS no later than October 15, 2008.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H5501	MA	Audit Findings	7/25/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must develop a corrective action plan to ensure that it is notifying its beneficiaries in accordance with Medicare Advantage Chapter 2, Section 50.3.1. The corrective action plan should include any other actions deemed necessary to demonstrate compliance.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H5501	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to ensure that all claims are adjudicated in accordance with 42 CFR 422,100(a) and (b)(1), 422.132, 422.502(g)(1). The corrective action plan should include training, internal auditing, correction of any policy and procedureas and any other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H5501	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to ensure that non-contracted provider clean claims are processed in accordance with 42 CFR 422.520(a)(1), Manual Chapter 11 - Section 100.20 and Manual Chapter 13- Section 40.1. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H5501	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to ensrue that interest is paid for all clean claims in accordance with 42 CFR 422.520(a)(2), manual Chapter 11- Section 100.2. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H5501	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to ensure that non-contracted provider claims are processed in accordance with 42 CFR 422.50(A)(3), Manual Chapter 11 - Section 100.2 and Manual Chapter 13 - Section 40.1. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also incude timeframes for providing the Regional Office with evidence of training as well as audit reports.	Open

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Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H5501	MA	Audit Findings	7/25/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The MAO must develop a corrective action plan to ensure that all denial notices comply with federal regulations provided by 42 CFR 422.568(d)(e), Manual Chapter 13 - Section 40.2.2. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional office with evidence of training as well as audit reports.	Open

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Health First	1-321-434-5617	H1099	MA-PD	Ad-Hoc Compliance Event	7/23/2008	Open	Chapter 99: Ad Hoc Compliance Event		CMS has reason to believe that HFHP is not meeting this requirement for the following reasons: ¿ In October 2007, CMS received a complaint from a representative of a Florida retail pharmacy stating that HFHP was not responding to the representative¿s request for HFHP¿s standard Part D retail contract. In our follow-up to this complaint, CMS requested the most current version of HFHP¿ s Part D retail pharmacy contract template. Upon our review of the contract template provided, we discovered that many of the CMS required provisions were not included. As a result, CMS staff requested HFHP ` s mail order, long-term care and home infusion pharmacy contract templates to review. Prior to HFHP submitting the requested materials, CMS staff provided substantial technical guidance to HFHP staff in their efforts to correct all of the Part D pharmacy contract templates. V V ¿ As of the January 4, 2008 submission to CMS, the only HFHP contract template that completely meets CMS standards is the long-term care pharmacy contract template. ¿ The HFHP retail pharmacy contract template contains all of the CMS-required provisions however, the Part D addendum within the template (Schedule C) is entitled ¿Medicare Part D Preferred Provider Retail Network.¿ HFHP did not submit to CMS a non-preferred retail pharmacy contract template for review. If all the retail pharmacies participating via SXC (HFHP¿s pharmacy benefit manager) to provide a Part D retail network for HFHP enrollees are considered preferred, then HFHP is misinterpreting the meaning of ¿preferred¿ versus ¿non-preferred¿ in the Part D context. Under these circumstances, the Part D addendum should be retitled without the reference to ¿preferred.¿ ¿ The HFHP home infusion pharmacy contract template consists of an underlying vendor agreement, four clearly marked and incorporated addenda, and a document entitled ¿Home Infusion Therapy Provider Network.¿ The last document is not referenced as addendum to the underlying agreement nor is it properly incorporated into the underlying agreement. Also, the home infusion template references SXC as a party to the contract section 3.1(e), yet the contract template is between HFHP and a home infusion pharmacy. The reference to SXC is inappropriate without further provisions added or the home infusion network being provided by SXC. ¿ The mail order pharmacy contract template consists of an underlying pharmacy agreement, five clearly marked and incorporated exhibits, and a document entitled ¿Mail Order Provider Network Medicare Part D Provisions.¿ The last document is not referenced as an addendum to the underlying agreement nor is it properly incorporated into the underlying agreement. Also, there is a typographical error at Section 2.3.2 (the word ¿hooks¿ should read ¿books¿), and the mail order language at Section 3.1(f) incorrectly states the pharmacy¿s obligation to provide enrollees information on the availability of generically equivalent drugs at the point of sale when CMS requires mail order pharmacies to provide the information at the point of delivery. Further, the agreement is between HFHP and a mail order pharmacy however there are references to SXC as a contracting party throughout the agreement, specifically at Section 3.1(e), (j), (m), (n), and Section 4.1. CMS requests that HFHP report back within 45 days of the date of this letter with a corrective action plan (CAP) which includes the following information: 1) A timeline for submitting to CMS PartD-compliant contract templates for all types of pharmacies. 2) A timeline for submitting to CMS a current list of all retail, home infusion, long-term care and mail order contracted Part D pharmacies. 3) A detailed plan that includes a timeline to correct all existing executed pharmacy agreements once CMS approves all Part D pharmacy contract templates submitted as part of the CAP.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Ad-Hoc Compliance Event	7/23/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is a request from the Centers for Medicare and Medicaid Services (CMS) for a corrective action plan (CAP) concerning WellCare¿ s failure to comply with CMS request for documentation of its financial solvency. On February 7, 2008, CMS sent WellCare a letter requesting by March 21, 2008 financial information related to both the entity with which CMS contracted as a prescription drug plan (PDP) sponsor, WeliCare Prescription Insurance, Inc. (WPI), and its parent organization, WellCare Health Plans, Inc (WHP). CMS issued this request pursuant to the Part D statute at § 1860D-15(f)(1) of the Social Security Act and the Part D regulations at 42 C.F.R. §423.514(a)(4) and in response to media reports raising questions about WellCare's financial viability following the announcement of a Federal investigation into WellCare's operations in October 2007. On February 26, 2008, CMS senior management held a conference call with WellCare officials to discuss the outstanding financial reports for WHP. WeilCare officials indicated that they could not provide audited financial statements at this time, but could provide unaudited statements by the March 21 deadline. As of the date of this letter, CMS has not received the requested financial information from WeliCare. Therefore, CMS has determined that WellCare is out of compliance with the requirement that it provide CMS with information demonstrating that it has a fiscally sound operation. CMS is requesting that WellCare complete a CAP by submitting the required financial information within 45 days from the date of this letter. WeilCare will remain under a CAP until it provides a complete and accurate response to CMS¿ request for financial information. The required financial reports consist of the balance sheets, statements of cash flows, and income statements for both WHP and WPI for the period of January 1, 2008 through February 29, 2008.	Open

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Harvard Pilgrim Health Care	1-617-509-1411	H7226	MA-PD	Ad-Hoc Compliance Event	7/22/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is a request for a corrective action plan (CAP) from Harvard Pilgrim Health Care (Harvard Pilgrim), which operated Medicare Advantage organization (MAO) contracts H2204 and H2206 in 2006 and currently operates MAO contract H7226, to develop and implement changes in procedures that ensure compliance with the Part D coordination of benefit (COB) requirements. Harvard Pilgrim has offered Part D prescription drug benefits under its MAO contracts since January 1, 2006. In accordance with 42 U.S.C. 1395w-133, 42 U.S.c. 1395w-134, and 42 CFR § 423.464, Part D sponsors are required to coordinate benefits with State Pharmaceutical Assistance Programs (SPAPs) and entities providing other prescription drug coverage for payment of premiums and coverage and payment of supplemental prescription drug benefits. When a Medicare Part D enrollee has other prescription drug coverage, COB allows the plans that provide coverage for this same beneficiary to determine each oftheir payment responsibilities. This process is necessary in order to avoid errors in payment. See Medicare Prescription Drug Benefit Manual, Chapter 14Coordination of Benefits. In December 2007, the Massachusetts SPAP, Prescription Advantage, informed the CMS Boston Regional Office that since October 2007, Prescription Advantage had requested reimbursement of overpayments Prescription Advantage made to Harvard Pilgrim in 2006. According to Prescription Advantage, Harvard Pilgrim accepted Prescription Advantage premiums on behalf of Prescription Advantage clients who received Part D benefits through their enrollment in a Harvard Pilgrim MA plan. The amount of these premiums was in excess of Harvard Pilgrim's Part D premium. Harvard Pilgrim applied the excess payment to their enrollees' Part C portion of the MA plan premium instead of returning the overpayment to Prescription Advantage. CMS' understanding is that Harvard Pilgrim has denied that request based on a provision in an agreement between Prescription Advantage and Harvard Pilgrim that states reasonable efforts to remedy underpayment or overpayment must be made in a timely manner. Harvard Pilgrim believes the request for reimbursement does not meet the terms of the agreement it has with Prescription Advantage. Regardless of the terms ofits agreement with Prescription Advantage, Harvard Pilgrim is obligated under its MAO contract with CMS to comply with Part D COB requirements stated in the Part D statute, regulations and policy guidance. Successful COB performance includes the sponsor's implementation ofprocedures to avoid payment errors, and for Part D sponsors to detect in a timely manner and execute reimbursement of erroneous payments. See Medicare	Open

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									Prescription Drug Benefit Manual, Chapter 14 - Coordination of Benefits, Appendix C. As a result ofHarvard Pilgrim's refusal to reimburse Prescription Advantage, Harvard Pilgrim is out of compliance with Part D requirements. CMS requests a CAP that explains how Harvard Pilgrim will develop and implement procedures to ensure compliance with the Part D coordination of benefits requirements. Specifically, the CAP should describe Harvard Pilgrim's plans for developing and implementing policies and procedures for accurately tracking both its enrollees' Part D premium amounts, reconciling those amounts with payments received by SPAPs on behalf ofthose enrollees, and making timely reimbursements to the SPAP when overpayments are detected. Please submit a CAP to address the issues described above to CMS within 45 days of the date of this letter. CMS will review Harvard Pilgrim's proposed CAP and indicate promptly to Harvard Pilgrim whether it is acceptable. CMS will then monitor Harvard Pilgrim's execution ofthe CAP through September 2008.	

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Wellpoint, Inc.	1-303-831-2514	S5596	Part D	Ad-Hoc Compliance Event	7/22/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is being sent to you to express the Centers for Medicare and Medicaid Services' (CMS) concerns about WellPoint's operation of its Medicare Advantage Prescription Drug contracts (MA-PD) and Prescription Drug Plan contracts: H0540, H0564, H1511, H1607, H1689, H1849, H2613, H3655, H4909, H5304, H5419, H5422, H5529, H5530, H5679, H5842, R5941, R9943, S5596, S5960, S2893. During 2007, CMS has become aware, through beneficiary and provider complaints, CMS' own analysis, and WellPoint's self-reporting, of numerous systemic errors that have resulted in episodes of non-compliance with Part C and D program requirements involving multiple contracts and an unknown number of beneficiaries. The problems caused by these systemic errors have been further complicated by WellPoint's failure to report these errors to CMS in a timely manner. The Part C regulation at 42 CFR §422.506(b)(4)(vi)(F) and (G) and Part D regulations at 42 CFR §423.504(b)(4)(vi)(F) and (G) require Part C and D sponsors to adopt policies and procedures for effective internal monitoring and for ensuring prompt detection and correction of noncompliance with program requirerpents. However, during 2007, WellPoint has failed to detect and correct several instances of non-compliance. However, the degree of past difficulty CMS has experienced in obtaining operational information, combined with more recently discovered issues, causes us to continue to question WellPoint's commitment to effective and timely communication on Part C and D matters. Most recently, CMS learned that WellPoint failed to report timely a telephonic enrollment system error. At this time, WellPoint has not provided CMS with the details of the telephonic error despite the fact that this system failure occurred in 2006. Other examples of systemic errors not reported timely by WellPoint include an error in the calculation of LIS premium amounts, resulting in erroneous premium bills being mailed to over 12,000 LIS beneftciaries, and a failure to calculate the correct true out-of-pocket (TrOOP) cost balances on explanations ofbeneftts (EOBs), resulting in a delay in the issuance ofEOBs. CMS expects open, responsive, and prompt communication with all Part C and D sponsors. Pursuant to 42 CFR §422.504(f) and §423.505(f), Part C and D plan sponsors are required to provide "all information to CMS that is necessary for CMS to administer and evaluate the program." This includes information on any matter "CMS may require, including, hut not limited to, program monitoring and oversight" and "quality assessments." Based on WellPoint's demonstrated pattern of insufficiently responsive communication, CMS directs WellPoint to submit a corrective action plan (CAP) for coming into compliance with Part	Open

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									C and D requirements concerning the timely and complete reporting of information to CMS. The CAP should include a statement of WellPoint's policies and procedures for keeping CMS up to date on all matters related to WellPoint's compliance with Part C and D program requirements. The policies and procedures should contain timeframes for reporting detected issues to CMS as well as identify the WellPoint employees responsible for reporting incidents and their resolution to CMS.	

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Wellpoint, Inc.	1-303-831-2514	S5960	Part D	Ad-Hoc Compliance Event	7/22/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is being sent to you to express the Centers for Medicare and Medicaid Services' (CMS) concerns about WellPoint's operation of its Medicare Advantage Prescription Drug contracts (MA-PD) and Prescription Drug Plan contracts: H0540, H0564, H1511, H1607, H1689, H1849, H2613, H3655, H4909, H5304, H5419, H5422, H5529, H5530, H5679, H5842, R5941, R9943, S5596, S5960, S2893. During 2007, CMS has become aware, through beneficiary and provider complaints, CMS' own analysis, and WellPoint's self-reporting, of numerous systemic errors that have resulted in episodes of non-compliance with Part C and D program requirements involving multiple contracts and an unknown number of beneficiaries. The problems caused by these systemic errors have been further complicated by WellPoint's failure to report these errors to CMS in a timely manner. The Part C regulation at 42 CFR §422.506(b)(4)(vi)(F) and (G) and Part D regulations at 42 CFR §423.504(b)(4)(vi)(F) and (G) require Part C and D sponsors to adopt policies and procedures for effective internal monitoring and for ensuring prompt detection and correction of noncompliance with program requirements. However, during 2007, WellPoint has failed to detect and correct several instances of non-compliance. However, the degree of past difficulty CMS has experienced in obtaining operational information, combined with more recently discovered issues, causes us to continue to question WellPoint's commitment to effective and timely communication on Part C and D matters. Most recently, CMS learned that WellPoint failed to report timely a telephonic enrollment system error. At this time, WellPoint has not provided CMS with the details of the telephonic error despite the fact that this system failure occurred in 2006. Other examples of systemic errors not reported timely by WellPoint include an error in the calculation of LIS premium amounts, resulting in erroneous premium bills being mailed to over 12,000 LIS beneficiaries, and a failure to calculate the correct true out-of-pocket (TrOOP) cost balances on explanations of benefits (EOBs), resulting in a delay in the issuance of EOBs. CMS expects open, responsive, and prompt communication with all Part C and D sponsors. Pursuant to 42 CFR §422.504(f) and §423.505(f), Part C and D plan sponsors are required to provide "all information to CMS that is necessary for CMS to administer and evaluate the program." This includes information on any matter "CMS may require, including, hut not limited to, program monitoring and oversight" and "quality assessments." Based on WellPoint's demonstrated pattern of insufficiently responsive communication, CMS directs WellPoint to submit a corrective action plan (CAP) for coming into compliance with Part	Open

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Wellpoint, Inc.	1-303-831-2514	S2893	Part D	Ad-Hoc Compliance Event	7/22/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is being sent to you to express the Centers for Medicare and Medicaid Services' (CMS) concerns about WellPoint's operation of its Medicare Advantage Prescription Drug contracts (MA-PD) and Prescription Drug Plan contracts: H0540, H0564, H1511, H1607, H1689, H1849, H2613, H3655, H4909, H5304, H5419, H5422, H5529, H5530, H5679, H5842, R5941, R9943, S5596, S5960, S2893. During 2007, CMS has become aware, through beneficiary and provider complaints, CMS' own analysis, and WellPoint's self-reporting, of numerous systemic errors that have resulted in episodes of non-compliance with Part C and D program requirements involving multiple contracts and an unknown number of beneficiaries. The problems caused by these systemic errors have been further complicated by WellPoint's failure to report these errors to CMS in a timely manner. The Part C regulation at 42 CFR §422.506(b)(4)(vi)(F) and (G) and Part D regulations at 42 CFR §423.504(b)(4)(vi)(F) and (G) require Part C and D sponsors to adopt policies and procedures for effective internal monitoring and for ensuring prompt detection and correction of noncompliance with program requirements. However, during 2007, WellPoint has failed to detect and correct several instances of non-compliance. However, the degree of past difficulty CMS has experienced in obtaining operational information, combined with more recently discovered issues, causes us to continue to question WellPoint's commitment to effective and timely communication on Part C and D matters. Most recently, CMS learned that WellPoint failed to report timely a telephonic enrollment system error. At this time, WellPoint has not provided CMS with the details of the telephonic error despite the fact that this system failure occurred in 2006. Other examples of systemic errors not reported timely by WellPoint include an error in the calculation of LIS premium amounts, resulting in erroneous premium bills being mailed to over 12,000 LIS beneficiaries, and a failure to calculate the correct true out-of-pocket (TrOOP) cost balances on explanations of benefits (EOBs), resulting in a delay in the issuance of EOBs. CMS expects open, responsive, and prompt communication with all Part C and D sponsors. Pursuant to 42 CFR §422.504(f) and §423.505(f), Part C and D plan sponsors are required to provide "all information to CMS that is necessary for CMS to administer and evaluate the program." This includes information on any matter "CMS may require, including, hut not limited to, program monitoring and oversight" and "quality assessments." Based on WellPoint's demonstrated pattern of insufficiently responsive communication, CMS directs WellPoint to submit a corrective action plan (CAP) for coming into compliance with Part	Open

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AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
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AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare must describe the actions it is taking to ensure that CMS requirements are followed for requesting information from beneficiaries to make elections complete. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare must describe the actions it is taking to ensure that beneficiaries are properly notified of receipt of the enrollment election and confirmation of enrollment acceptance within the timeframes specified by CMS. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare must describe the actions it is taking to ensure that beneficiaries are notified of enrollment denials within the timeframes specified by CMS. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
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AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare must describe the actions it is taking to ensure that documentation of Medicaid eligibility is contained in all enrollments into the Special Needs Plan in accordance with CMS policy and regulations. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 02 - Enrollment and Disenrollment		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 03 - Marketing		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 03 - Marketing		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 03 - Marketing		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 03 - Marketing		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 06 - Provider Relations		Describe actions AlohaCare is taking to ensure it credentials/recredentials contracted providers in accordance with CMS requirements. This must include policy and procedure revisions as applicable for the health plan. The corrective action must include internal health plan audits to ensure compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 11 - Contracts		Describe actions AlohaCare is taking to ensure its provider contracts including downstream provider contracts contain the Medicare required provisions in accordance with CMS requirements. Submit to CMS the corrective action for amending the downstream provider contracts and date certain for its completion. Submit the missing Medicare contracts for physicians, EM (general practice) and AD (oncologist). The corrective action must include internal health plan audits to ensure compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must submit a new universe for WSGV1 (Grievances) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must submit a new universe for WSGV1 (Grievances) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must submit a new universe for WSGV1 (Grievances) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must submit a new universe for WSGV1 (Grievances) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.	Open

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AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must describe the steps that it is taking to address the identified deficiencies. Corrective action should include at a minimum, the following: 1) documentation to justify the denial of the claim, 2) analysis and correction of its EDI claims look up to permit processors to view referring physicians, 3) analysis and correction of the plans process to ensure prior authorizations are provided for all services provided by non-contracted providers, 4) documentation to support the plans decision to reverse a denied claim, 5) implement appropriate training to ensure staff are instructed on the procedures for processing claims from non-contracted providers, 6) implement appropriate training to instruct contracting and non-contracting providers on the procedures for appropriate referrals and prior authorizations, 7) AlohaCare should conduct an internal audit on denied claims each month. This audit should evaluate whether the claims are being properly denied, processed timely, and whether proper denial language is included in the notices. Lastly, since AlohaCares claims process was revised during the audit period and most of the deficiencies were found for the period prior to the change. AlohaCare must submit a new universe for paid and denied claims. Once produced, CMS will do a focused desk review to determine compliance. Each sample will contain a particular audit period based on potential universe size.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must describe the actions that it is taking to ensure that it pays clean claims to non-contracted providers within 30 days of receipt. Corrective action should include an analysis of the non-complaint claims (#1, #15, #16, #17, #18, #20, and #21) to determine outcome of the referrals and internal backlog. AlohaCare should also develop a system to track referrals of clean claims to other departments and the results of these referrals. Furthermore, it should develop a system to identify clean claims that may not be paid in a timely manner and plan for monitoring its own performance for compliance on an ongoing basis.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must describe the actions it is taking to ensure that interest paid on clean claims from non-contracted providers is in accordance with CMS policy and regulations. As part of the required corrective action, AlohaCare must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must revise its policies and procedures to ensure that claims are processed timely. AlohaCare should also conduct periodic internal audits to evaluate whether claims are being developed appropriately, processed accurately and resolved timely.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The policy and procedures on Claim Denial Member Notices which became effective on March 1, 2008 incorporates some of the required information for a denial notice. It should further revise the policy to ensure that the notice to the member clearly states the service that was denied, the specific denial reason and the specific denial amount. The revised EOB must be reviewed by the RO. AlohaCare should revise the Remittance Advice to the provider to include the same elements as those found in the EOB. It should also revise the Evidence of Coverage and Remittance Advice to document interest paid on clean claims.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open

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AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Describe actions AlohaCare is taking to ensure that it issues the CMS required NDMC or an RO-approved modification of the NDMC for adverse standard or expedited pre-service organization determinations. AlohaCare must also describe the actions it is taking to ensure that the NDMC contains denial reasons that are specific, clear and easily understood by the beneficiary in accordance with CMS policy and regulations. The corrective action must include internal health plan audits to ensure compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Describe actions AlohaCare is taking to ensure that it is meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. The corrective action must include internal health plan audits to ensure compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Describe actions AlohaCare is taking to ensure that it issues the CMS required NDMC or an RO-approved modification of the NDMC for adverse standard or expedited pre-service organization determinations. AlohaCare must also describe the actions it is taking to ensure that the NDMC contains denial reasons that are specific, clear and easily understood by the beneficiary in accordance with CMS policy and regulations. The corrective action must include internal health plan audits to ensure compliance.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must submit to CMS a revised policy and procedure, including flowcharts and appropriate CMS notices, correctly describing the "Hospital Discharge Appeals Rights" process. The corrective action must include internal health plan audits to ensure compliance with CMS requirements.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
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AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare must submit a new universe for WSRP1 (Favorable Standard Pre-Service Reconsiderations) to CMS for further action. This will be done as part of a Focused Audit and the review period will be determined at a later date. AlohaCare will be notified of the review period for the new universe for this sample.	Open
AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open

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AlohaCare	1-808-973-2476	H5969	MA	Audit Findings	7/18/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AlohaCare submitted revised policies and procedures dated March 2008 which includes the requirements for this element and no additional corrective action is required.	Open
AlohaCare	1-808-973-2476	H5969	MA-PD	Audit Findings	7/18/2008	Open	Chapter 02: Provider Communication		AlohaCare must revise its policy and procedures to include a provision to provide retrospective notice of formulary changes to authorized prescribers if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer.	Open
AlohaCare	1-808-973-2476	H5969	MA-PD	Audit Findings	7/18/2008	Open	Chapter 15: Policies and Procedures		FM03: AlohaCare must revise policy and procedures to include: 1) a provision with a description of the procedures for providing a notice of formulary changes to entities providing other prescription drug coverage, 2) a provision with a description of the procedures for providing retrospective notice to entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacture, and 3) a description of the method(s) used to provide notification of formulary changes. PT05: AlohaCare must revise policy and procedures to include provisions describing the P and T Committees review of: 1) other utilization management processes, including quantity limits, generic substitution, and therapeutic interchange, and 2) recommendations regarding the procedures for medical review of non-formulary drug requests. ER13: AlohaCare must revise policy and procedures to include provisions for: 1) documenting and retaining beneficiary confirmation of enrollment, 2) resubmitting the enrollment transaction to CMS with the appropriate flag, and 3) properly denying the enrollment. MR09: AlohaCare must revise policy and procedures to include a provision that ensures affected enrollees are provided with a 60 day supply of the Part D drug. PR01: AlohaCare must revise policy and procedures to include a provision that specifies for what purposes personal health or enrollment information is used within the organization and to whom the sponsor discloses such information outside the organization.	Open

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TriHealth SeniorLink	1-513-569-5607	H3614	MA	Audit Findings	7/18/2008	Open	Section 1 - Clinical PACE Elements		Corrective Action Required: White out can not be used on a legal document. If a mistake is made, draw a single a line through the entry and write ¿mistaken entry¿ rather than error. ¿The word error could seem to indicate that a mistake in care was made.¿ (Documentation Legal Aspects On Aspects Online Nursing).¿ The writer person should draw a line through it, write their initials and delete the entry. Submit plan to educate staff regarding proper medical records documentation. Plan should include, but is not li not limited to training, development of internal quality control mechanisms, creation and / or update to policies and procedures and annual re-training as may be necessary. Notes/Recommendations: No write out can be use in a participant¿s medical record. All employees that document in the Pace organization should be in-service on Documentation Guidelines.	Open
TriHealth SeniorLink	1-513-569-5607	H3614	MA	Audit Findings	7/18/2008	Open	Section 1 - Clinical PACE Elements		Corrective Action Required: Tri Health Senior Link should reassess participant¿s blood pressure, when their goals are not being met. Assessments should be conducted to determine if current medications are effective in lowering the blood press blood pressure, and if participant is non-compliance with her medication regimen. The IDT team should develop goals that are individualized for each participant.	Open

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EmblemHealth Inc.	1-646-447-6200	S5741	Part D	Ad-Hoc Compliance Event	7/17/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is a request for a corrective action plan (CAP) from HIP Health Plan of New York (HIP) to address Medicare Part D contract year 2009 (CY2009) fonnulary development issues for Prescription Drug Plan (PDP) contract S5741. During the CY2009 fonnulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that HIP's fonnulary submissions for Stage 1 and Stage 2 consistently contained high numbers of outliers in comparison to other sponsors. Examples of HIP's outliers included large numbers of two-drug requirement outliers that were generated after HIP utilized a classification system that was much too granular to allow for the required two drugs per category/class and large numbers of quantity limit outliers. CMS is especially concerned that no one reviewed the initial fonnulary submission prior to its transmittal to CMS to check for two drugs per category/class. In several instances, it was evident to CMS that important memos, guidance, and technical manuals had not been carefully reviewed. As a reminder, an approved fonnulary is a component of an approvable bid, and HIP must have an approved bid to contract for CY2009. So far this year, CMS has had to devote an inordinate amount of our pharmacists' time and expertise to addressing HIP's fonnulary submission issues. Throughout the rest of this year and into 2009, CMS expects HIP will take steps to ensure that it can efficiently and accurately administer its fonnulary in 2009. CMS staff worked intensely with all sponsors throughout the fonnulary review processes for CY2006 and CY2007. However, during 2008, in preparation for the fourth year of the Part D program, CMS expects all Part D sponsors, including HIP, to have developed the expertise and resources necessary to complete the CY2009 fonnulary review process with minimal technical assistance from CMS. In response to this CAP request, CMS asks that HIP submit the following to CMS: ¿ Updated policies and procedures explaining how HIP will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2009 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission as well as a plan describing how HIP will be prepared to accommodate the quick tum-around times for future formulary submissions. ¿ A discussion of the steps HIP will take to ensure it can meet the requirements for the CY2010 formulary review process. This portion of the CAP should describe any arrangements HIP has made to ensure that it maintains adequate oversight and control over any organizations or individuals contracted with to provide formulary services on HIP's behalf. ¿ A plan for how HIP will ensure that the CY2009 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. CMS recognizes that HIP is affiliated with other sponsors that will receive a CAP request	Open

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EmblemHealth Inc.	1-860-674-7042	H3528	MA-PD	Ad-Hoc Compliance Event	7/17/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is a request for a corrective action plan (CAP) from Connecticare, Inc. (Connecticare) to address Medicare Part 0 contract year 2009 (CY2009) formulary development issues for Medicare Advantage Prescription Drug Plan (MA-PD) contracts H3528 and H6504. During the CY2009 formulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that Connecticare's formulary submissions for Stage 1 and Stage 2 consistently contained high numbers of outliers in comparison to other sponsors. Examples of Connecticare's outliers included large numbers of two-drug requirement outliers that were generated after Connecticare utilized a classification system that was much too granular to allow for the required two drugs per category/class and large numbers of quantity limit outliers. CMS is especially concerned that no one reviewed the initial formulary submission prior to its transmittal to CMS to check for two drugs per category/class. In several instances, it was evident to CMS that important memos, guidance, and technical manuals had not been carefully reviewed. As a reminder, an approved formulary is a component of an approvable bid, and Connecticare must have an approved bid to contract for CY 2009. So far this year, CMS has had to devote an inordinate amount of our pharmacists' time and expertise to addressing Connecticare's formulary submission issues. Throughout the rest of this year and into 2009, CMS expects Connecticare will take steps to ensure that it can efficiently and accurately administer its formulary in 2009. CMS staff worked intensely with all sponsors throughout the formulary review processes for CY2006 and CY2007. However, during 2008, in preparation for the fourth year of the Part D program, CMS expects all Part D sponsors, including Connecticare, to have developed the expertise and resources necessary to complete the CY2009 formulary review process with minimal technical assistance from CMS. In response to this CAP request, CMS asks that Connecticare submit the following to CMS: ¿ Updated policies and procedures explaining how Connecticare will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2009 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission as well as a plan describing how Connecticare will be prepared to accommodate the quick tum-around times for future formulary submissions. ¿ A discussion of the steps Connecticare will take to ensure it can meet the requirements for the CY201 0 formulary review process. This portion of the CAP should describe any arrangements Connecticare has made to ensure that it maintains adequate oversight and control over any organizations or individuals contracted with to provide formulary services on Connecticare' s behalf. ¿ A plan for how Connecticare will ensure that the CY2009 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. CMS recognizes that Connecticare is affiliated with other sponsors that will receive a CAP	Open

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EmblemHealth Inc.	1-860-674-7042	H6504	MA-PD	Ad-Hoc Compliance Event	7/17/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is a request for a corrective action plan (CAP) from Connecticare, Inc. (Connecticare) to address Medicare Part 0 contract year 2009 (CY2009) formulary development issues for Medicare Advantage Prescription Drug Plan (MA-PD) contracts H3528 and H6504. During the CY2009 formulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that Connecticare's formulary submissions for Stage 1 and Stage 2 consistently contained high numbers of outliers in comparison to other sponsors. Examples of Connecticare's outliers included large numbers of two-drug requirement outliers that were generated after Connecticare utilized a classification system that was much too granular to allow for the required two drugs per category/class and large numbers of quantity limit outliers. CMS is especially concerned that no one reviewed the initial formulary submission prior to its transmittal to CMS to check for two drugs per category/class. In several instances, it was evident to CMS that important memos, guidance, and technical manuals had not been carefully reviewed. As a reminder, an approved formulary is a component of an approvable bid, and Connecticare must have an approved bid to contract for CY 2009. So far this year, CMS has had to devote an inordinate amount of our pharmacists' time and expertise to addressing Connecticare's formulary submission issues. Throughout the rest of this year and into 2009, CMS expects Connecticare will take steps to ensure that it can efficiently and accurately administer its formulary in 2009. CMS staff worked intensely with all sponsors throughout the formulary review processes for CY2006 and CY2007. However, during 2008, in preparation for the fourth year of the Part D program, CMS expects all Part D sponsors, including Connecticare, to have developed the expertise and resources necessary to complete the CY2009 formulary review process with minimal technical assistance from CMS. In response to this CAP request, CMS asks that Connecticare submit the following to CMS: ¿ Updated policies and procedures explaining how Connecticare will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2009 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission as well as a plan describing how Connecticare will be prepared to accommodate the quick tum-around times for future formulary submissions. ¿ A discussion of the steps Connecticare will take to ensure it can meet the requirements for the CY201 0 formulary review process. This portion of the CAP should describe any arrangements Connecticare has made to ensure that it maintains adequate oversight and control over any organizations or individuals contracted with to provide formulary services on Connecticare' s behalf. ¿ A plan for how Connecticare will ensure that the CY2009 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. CMS recognizes that Connecticare is affiliated with other sponsors that will receive a CAP	Open

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	7/15/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		ATRIO Health Plans must revised its policies and procedures to ensure it notifies members in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving a request for an expedited organization determination. ATRIO Health Plans must: 1.) Conduct training of appropriate staff on expedited organization determination notification procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 2.) Establish a mechanism for ongoing monitoring of this area to ensure continued compliance. 3.) Conduct an internal audit each month of its expedited organization determination notification process. This audit should evaluate whether the organization is submitting member notifications timely. 4.) Submit a monthly summary report to the regional office of its findings until further notice. The summary report should include: tile of the auditor(s), the audit methodology, and the results of the audit. A report must be submitted even if no requests were received during that reporting month. This will be considered a "negative report" for reporting purposes.	Open
Elder Svc Pln/E Boston Health Center	1-617-569-5800	H2223	MA	Audit Findings	7/14/2008	Closed	Section 1 - Clinical PACE Elements		The PACE Organization will analyze implementation of the new Infection Control/HR/Employee Health/Direct Care Oversight process, and send results, showing outcomes, trends and actions to CMS for 1, 2, and 3Q2008 at a minimum. Plese submit these materials quarterly, to be completed by 10/31/2008. Data is required to demonstrate sustained improvement. Include, at a minimum: 1. Clearly articulated ESP thresholds and timeframes for adherence to all relevant Policies and Procedures. 2. Rates of completed orientation and annual performance reviews for all ESP staff and contracted direct care workers due this period. Include rate of completion for all required training. 3. Rate of completeion of PPD testing, or documentation. 4. Rate of full doucmentation of hepatitis B status, vaccination, declination. 5. Rate of unlicensed staff competencies evaluated prior to starting work with participants, and per Policies and Procedures. 6. Any ESP action taken to address problems, or intended to make process more efficient/effective overall, by discipline, by Center, etc.	Closed

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Elder Svc Pln/E Boston Health Center	1-617-569-5800	H2223	MA	Audit Findings	7/14/2008	Closed	Section 2A-Administrative: PACE Elements		The PACE organization must execute a valid contract with New England Courier that meets all regulatory requirements of §460.70, with specific sections noted above. The PACE organization must submit the executed contract between New England Courier and ESP, EBNHC for review by CMS and the State. All policies and procedures related to HIPAA privacy and security must be updated to reinforce the protection of a participants' confidentiality of health information. The PACE organization must develop a process to ensure that all individually identifiable health care information is protected with pharmacy partners, couriers and other appropriate contractors. Conduct an in-service with all contractors to reeducate partners on the importance of protecting individually identifiable health care information. Develop a process to maintain the integrity of prescription drugs delivered to participants. This process should not impair the participant's ability to open the package.	Closed

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EmblemHealth Inc.	1-518-446-8092	H5528	MA-PD	Ad-Hoc Compliance Event	7/11/2008	Open	Chapter 99: Ad Hoc Compliance Event		In response to this CAP request, CMS asks that your organization submit the following to CMS: - Updated policies and procedures explaining how your organization will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2009 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission as well as a plan describing how your organization will be prepared to accommodate the quick tum-around times for future formulary submissions. - A discussion of the steps your organization will take to ensure it can meet the requirements for the CY201 0 formulary review process. This portion of the CAP should describe any arrangements your organization has made to ensure that it maintains adequate oversight and control over any organizations or individuals contracted with to provide formulary services on your organization' s behalf. - A plan for how your organization will ensure that the CY2009 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. CMS recognizes that your organization is affiliated with other sponsors that will receive a CAP request that mirrors this one. The sponsors may individually submit CAPs to CMS or they may submit one CAP that reflects the actions that sponsors will undertake. If a single CAP is submitted for several sponsors, a page ofthe CAP must include (a) language indicating that all sponsors signing the CAP will undertake the actions outlined in the submission and (b) signature of the sponsor's CEO, compliance officer, or both. CMS requests your organization submit the CAP by Wednesday, August 27,2008 at 5:00 p.m. In the event your organization does not successfully satisfy its CAP, CMS will consider additional compliance actions, including the imposition of intermediate sanctions. CMS also notes that your organization's failure to meet the Part D formulary submission and approval requirements during CY2009 may result in CMS electing not to renew your organization's MA-PD contract for CY201O.	Open
EmblemHealth Inc.	1-518-446-8092	H5528	MA-PD	Ad-Hoc Compliance Event	7/11/2008	Open	Chapter 99: Ad Hoc Compliance Event			Open

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EmblemHealth Inc.	1-860-674-7042	H6504	MA-PD	Ad-Hoc Compliance Event	7/11/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is a request for a corrective action plan (CAP) from Connecticare, Inc. (Connecticare) to address Medicare Part 0 contract year 2009 (CY2009) formulary development issues for Medicare Advantage Prescription Drug Plan (MA-PD) contracts H3528 and H6504. During the CY2009 formulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that Connecticare's formulary submissions for Stage 1 and Stage 2 consistently contained high numbers of outliers in comparison to other sponsors. Examples of Connecticare's outliers included large numbers of two-drug requirement outliers that were generated after Connecticare utilized a classification system that was much too granular to allow for the required two drugs per category/class and large numbers of quantity limit outliers. CMS is especially concerned that no one reviewed the initial formulary submission prior to its transmittal to CMS to check for two drugs per category/class. In several instances, it was evident to CMS that important memos, guidance, and technical manuals had not been carefully reviewed. As a reminder, an approved formulary is a component of an approvable bid, and Connecticare must have an approved bid to contract for CY 2009. So far this year, CMS has had to devote an inordinate amount of our pharmacists' time and expertise to addressing Connecticare's formulary submission issues. Throughout the rest of this year and into 2009, CMS expects Connecticare will take steps to ensure that it can efficiently and accurately administer its formulary in 2009. CMS staff worked intensely with all sponsors throughout the formulary review processes for CY2006 and CY2007. However, during 2008, in preparation for the fourth year of the Part D program, CMS expects all Part D sponsors, including Connecticare, to have developed the expertise and resources necessary to complete the CY2009 formulary review process with minimal technical assistance from CMS. In response to this CAP request, CMS asks that Connecticare submit the following to CMS: ¿ Updated policies and procedures explaining how Connecticare will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2009 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission as well as a plan describing how Connecticare will be prepared to accommodate the quick tum-around times for future formulary submissions. ¿ A discussion of the steps Connecticare will take to ensure it can meet the requirements for the CY201 0 formulary review process. This portion of the CAP should describe any arrangements Connecticare has made to ensure that it maintains adequate oversight and control over any organizations or individuals contracted with to provide formulary services on Connecticare' s behalf. ¿ A plan for how Connecticare will ensure that the CY2009 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. CMS recognizes that Connecticare is affiliated with other sponsors that will receive a CAP request that mirrors this one. The sponsors may individually submit CAPs to CMS or they	Open

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EmblemHealth Inc.	1-518-446-6941	H4729	MA-PD	Ad-Hoc Compliance Event	7/11/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is a request for a corrective action plan (CAP) from Group Health, Inc. (Group Health) to address Medicare Part D contract year 2009 (CY2009) formulary development issues for Medicare Advantage Prescription Drug Plan (MA-PD) contracts H4729 and H5528. During the CY2009 formulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that Group Health's formulary submissions for Stage 1 and Stage 2 consistently contained high numbers of outliers in comparison to other sponsors. Examples of Group Health's outliers included large numbers of two-drug requirement outliers that were generated after Group Health utilized a classification system that was much too granular to allow for the required two drugs per category/class and large numbers of quantity limit outliers. CMS is especially concerned that no one reviewed the initial formulary submission prior to its transmittal to CMS to check for two drugs per category/class. In several instances, it was evident to CMS that important memos, guidance, and technical manuals had not been carefully reviewed. As a reminder, an approved formulary is a component of an approvable bid, and Group Health must have an approved bid to contract for CY 2009. So far this year, CMS has had to devote an inordinate amount of our pharmacists' time and expertise to addressing Group Health's formulary submission issues. Throughout the rest of this year and into 2009, CMS expects Group Health will take steps to ensure that it can efficiently and accurately administer its formulary in 2009. CMS staff worked intensely with all sponsors throughout the formulary review processes for CY2006 and CY2007. However, during 2008, in preparation for the fourth year of the Part D program, CMS expects all Part D sponsors, including Group Health, to have developed the expertise and resources necessary to complete the CY2009 formulary review process with minimal technical assistance from CMS. In response to this CAP request, CMS asks that Group Health submit the following to CMS: ¿ Updated policies and procedures explaining how Group Health will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2009 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission as well as a plan describing how Group Health will be prepared to accommodate the quick tum-around times for future formulary submissions. ¿ A discussion of the steps Group Health will take to ensure it can meet the requirements for the CY201 0 formulary review process. This portion of the CAP should describe any arrangements Group Health has made to ensure that it maintains adequate oversight and control over any organizations or individuals contracted with to provide formulary services on Group Health's behalf. ¿ A plan for how Group Health will ensure that the CY2009 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems.	Open

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									CMS recognizes that Group Health is affiliated with other sponsors that will receive a CAP request that mirrors this one. The sponsors may individually submit CAPs to CMS or they may submit one CAP that reflects the actions that sponsors will undertake. If a single CAP is submitted for several sponsors, a page of the CAP must include (a) language indicating that all sponsors signing the CAP will undertake the actions outlined in the submission and (b) signature of the sponsor's CEO, compliance officer, or both.	
Guildnet, Inc.	1-917-386-9129	H6864	MA-PD	Ad-Hoc Compliance Event	7/11/2008	Open	Chapter 99: Ad Hoc Compliance Event		In response to this CAP request, CMS asks that your organization submit the following to CMS: - Updated policies and procedures explaining how your organization will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2009 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission as well as a plan describing how your organization will be prepared to accommodate the quick tum-around times for future formulary submissions. - A discussion of the steps your organization will take to ensure it can meet the requirements for the CY201 0 formulary review process. This portion of the CAP should describe any arrangements your organization has made to ensure that it maintains adequate oversight and control over any organizations or individuals contracted with to provide formulary services on your organization' s behalf. - A plan for how your organization will ensure that the CY2009 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. CMS recognizes that your organization is affiliated with other sponsors that will receive a CAP request that mirrors this one. The sponsors may individually submit CAPs to CMS or they may submit one CAP that reflects the actions that sponsors will undertake. If a single CAP is submitted for several sponsors, a page ofthe CAP must include (a) language indicating that all sponsors signing the CAP will undertake the actions outlined in the submission and (b) signature of the sponsor's CEO, compliance officer, or both. CMS requests your organization submit the CAP by Wednesday, August 27,2008 at 5:00 p.m. In the event your organization does not successfully satisfy its CAP, CMS will consider additional compliance actions, including the imposition of intermediate sanctions. CMS also notes that your organization's failure to meet the Part D formulary submission and approval requirements during CY2009 may result in CMS electing not to renew your organization's MA-PD contract for CY201O.	Open

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CIGNA	1-602-371-2429	H0354	MA	Audit Findings	7/3/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The organization must develop a plan to ensure compliance with the regulatory requirement in issuing organization determinations in an expedited manner. The organization has submitted a corrective action plan prior to the exit conference. CMS will monitor this corrective action plan and will conduct a sample audit of this element to ensure compliance.	Open
CIGNA	1-602-371-2429	H0354	MA-PD	Audit Findings	7/3/2008	Open	Chapter 03: Marketing and Beneficiary Information		No action is required. CIGNA Healthcare of Arizona, Inc., submitted revised materials for file and use, which were submitted and accepted on February 4, 2008.	Closed
CIGNA	1-602-371-2429	H0354	MA-PD	Audit Findings	7/3/2008	Open	Chapter 03: Marketing and Beneficiary Information		CIGNA Healthcare of Arizona, Inc. must implement corrective action and revise policies and procedures to incorporate quality controls to ensure that data entry errors are identified during the negative formulary notification process and that explanation of benefits include notification and ensure timely notification to affected beneficiaries. CIGNA Healthcare of Arizona, Inc., must conduct training of appropriate staff on the revised policies and procedures and submit documentation to the CMS Regional Office that details the nature of the training, including: the materials used in the training, the individuals that conduct the training, and the individuals that attend the training.	Closed
CIGNA	1-602-371-2429	H0354	MA-PD	Audit Findings	7/3/2008	Open	Chapter 15: Policies and Procedures		CIGNA Healthcare of Arizona, Inc., must revise and submit to the CMS Regional Office the policies and procedures to incorporate the specific reference to notify the beneficiary within 10 days after enrollments reject due to employer or union group drug coverage. In addition, CIGNA Healthcare of Arizona, Inc., should submit policies and procedures, including methods of notice, incorporating the requirement to specifically include retrospective notice to CMS when a Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer.	Open
Tenet Healthcare Corporation	1-504-849-4500 Ext. 8580	H1961	MA	Ad-Hoc Compliance Event	7/1/2008	Open	Chapter 99 - Ad-Hoc Compliance Event		The CAP must include the following: ¿ Effective July 1, 2008, Peoples Health will enroll the affected beneficiaries into H1961 PBP001 or H1961 PBP002. ¿ During the July 1, 2008 through December 31, 2008 period, Peoples Health will not be eligible for any Part D payments for these beneficiaries, including direct subsidy, reinsurance subsidies, low-income subsidies, or risk sharing payments. ¿ Peoples Health will provide the affected beneficiaries with prescription drug coverage identical to that which would have been provided if the beneficiaries were enrolled in the Part D benefit. ¿ Effective January 1, 2009, Peoples Health will enroll the affected beneficiaries in a non-Reinsurance Payment Demonstration Part D plan. CMS is waiving the requirement found in 42 C.F.R. 422.624(a), which states that beneficiaries enrolled in an MAPD may not elect an MA plan that does not provide qualified prescription drug coverage. This will allow the beneficiaries to enroll in Peoples Health without getting the Part D benefit from this plan during the July 1, 2008 through December 31, 2008 period. This is being waived to allow beneficiaries to be enrolled into the MA portion of the Peoples Health contract H1961 and not elect the prescription drug coverage offered by the plan. This waiver would allow Peoples Health to retain enrollees into their employer group plan without being out of compliance as a Part D demonstration payment plan.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
The Regence Group	1-503-375-4471	H1349	MA	Audit Findings	6/27/2008	Closed	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan disenrolls Medicare members, when appropriate, upon receipt of a request for disenrollment. The Cost plan annotates its own system and the CMS system with the correct disenrollment effective date.	On May 30, 2008, RBI officially requested to nonrenew Contract number H1349 effective January 1, 2009. On June 5, 2008, CMS sent the non-renewal acknowledgement to the organization via HPMS. Due to the upcoming nonrenewal of the contract, we are releasing RBI from the Corrective Action Plans for audits ID#10857 and ID#12337. The audits have been closed and we require no further actions from RBI related to these audits. CMS will continue to monitor the organization¿s performance through monthly Issue Management meetings until December 31, 2008.	Closed
The Regence Group	1-503-375-4471	H1349	MA	Audit Findings	6/27/2008	Closed	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost plan must refund all amounts incorrectly collected from its Medicare members.	On May 30, 2008, RBI officially requested to nonrenew Contract number H1349 effective January 1, 2009. On June 5, 2008, CMS sent the non-renewal acknowledgement to the organization via HPMS. Due to the upcoming nonrenewal of the contract, we are releasing RBI from the Corrective Action Plans for audits ID#10857 and ID#12337. The audits have been closed and we require no further actions from RBI related to these audits. CMS will continue to monitor the organization¿s performance through monthly Issue Management meetings until December 31, 2008.	Closed
The Regence Group	1-503-375-4471	H1349	MA	Audit Findings	6/27/2008	Closed	Chapter 17, Subpart D - Enrollment and Disenrollment	The Cost Plan provides the member a copy of the member's request for disenrollment.	On May 30, 2008, RBI officially requested to nonrenew Contract number H1349 effective January 1, 2009. On June 5, 2008, CMS sent the non-renewal acknowledgement to the organization via HPMS. Due to the upcoming nonrenewal of the contract, we are releasing RBI from the Corrective Action Plans for audits ID#10857 and ID#12337. The audits have been closed and we require no further actions from RBI related to these audits. CMS will continue to monitor the organization¿s performance through monthly Issue Management meetings until December 31, 2008.	Closed
The Regence Group	1-503-375-4471	H1349	MA	Audit Findings	6/27/2008	Closed	Chapter 17, Subpart D - Enrollment and Disenrollment	The written acknowledgement notice, sent in response to the beneficiary's enrollment form, meets CMS requirements and specifies the correct effective date of enrollment.	On May 30, 2008, RBI officially requested to nonrenew Contract number H1349 effective January 1, 2009. On June 5, 2008, CMS sent the non-renewal acknowledgement to the organization via HPMS. Due to the upcoming nonrenewal of the contract, we are releasing RBI from the Corrective Action Plans for audits ID#10857 and ID#12337. The audits have been closed and we require no further actions from RBI related to these audits. CMS will continue to monitor the organization¿s performance through monthly Issue Management meetings until December 31, 2008.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
The Regence Group	1-503-375-4471	H1349	MA	Audit Findings	6/27/2008	Closed	Chapter 17, Subpart D - Enrollment and Disenrollment	The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	On May 30, 2008, RBI officially requested to nonrenew Contract number H1349 effective January 1, 2009. On June 5, 2008, CMS sent the non-renewal acknowledgement to the organization via HPMS. Due to the upcoming nonrenewal of the contract, we are releasing RBI from the Corrective Action Plans for audits ID#10857 and ID#12337. The audits have been closed and we require no further actions from RBI related to these audits. CMS will continue to monitor the organization¿s performance through monthly Issue Management meetings until December 31, 2008.	Closed
The Regence Group	1-503-375-4471	H1349	MA	Audit Findings	6/27/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals		On May 30, 2008, RBI officially requested to nonrenew Contract number H1349 effective January 1, 2009. On June 5, 2008, CMS sent the non-renewal acknowledgement to the organization via HPMS. Due to the upcoming nonrenewal of the contract, we are releasing RBI from the Corrective Action Plans for audits ID#10857 and ID#12337. The audits have been closed and we require no further actions from RBI related to these audits. CMS will continue to monitor the organization¿s performance through monthly Issue Management meetings until December 31, 2008.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Ad-Hoc Compliance Event	6/18/2008	Closed	Chapter 02 - Enrollment and Disenrollment		The CAP should include the following information: 1. A written background summary the issue. 2. A list of which contracts are affected. 3. A description of the actions Kaiser will take to correct this deficiency. 4. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. 5. A robust and meaningful outreach effort plan to educate individuals about this change, ensuring that the information clear states that the individuals are not limited in any way to selecting only another Kaiser product. Outreach efforts should encourage each individual to review all options offered by employers/former employers in the decision making process. 6. Selection of one plan (one PBP serving each applicable area) into which all individuals from the STRS/PERS group will default if they have not selected another enrollment option. In other words, Kaiser may not distribute these individuals across various products within service areas. The ¿default¿ into an individual KPSA plan follows the requirements provided in section 50.7 (option 1) of the MA enrollment guidance with 2 key adjustments that must also be included in the CAP: a. Plans to provide information and a simple mechanism to decline enrollment, to provided no later than October 31, 2008, to ensure individuals are aware before the start of the AEP, and b. Notice to the individuals of an available SEP beginning on November 1, 2008 and ending on January 31, 2009, which is not limited to selecting only Kaiser products. 7. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place. 8. Notification and/or script to the members, including their submission for Regional Office review and approval.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6050	MA	Ad-Hoc Compliance Event	6/18/2008	Closed	Chapter 02 - Enrollment and Disenrollment		The CAP should include the following information: 1. A written background summary the issue. 2. A list of which contracts are affected. 3. A description of the actions Kaiser will take to correct this deficiency. 4. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. 5. A robust and meaningful outreach effort plan to educate individuals about this change, ensuring that the information clear states that the individuals are not limited in any way to selecting only another Kaiser product. Outreach efforts should encourage each individual to review all options offered by employers/former employers in the decision making process. 6. Selection of one plan (one PBP serving each applicable area) into which all individuals from the STRS/PERS group will default if they have not selected another enrollment option. In other words, Kaiser may not distribute these individuals across various products within service areas. The ¿default¿ into an individual KPSA plan follows the requirements provided in section 50.7 (option 1) of the MA enrollment guidance with 2 key adjustments that must also be included in the CAP: a. Plans to provide information and a simple mechanism to decline enrollment, to provided no later than October 31, 2008, to ensure individuals are aware before the start of the AEP, and b. Notice to the individuals of an available SEP beginning on November 1, 2008 and ending on January 31, 2009, which is not limited to selecting only Kaiser products. 7. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place. 8. Notification and/or script to the members, including their submission for Regional Office review and approval.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6052	MA	Ad-Hoc Compliance Event	6/18/2008	Closed	Chapter 02 - Enrollment and Disenrollment		The CAP should include the following information: 1. A written background summary the issue. 2. A list of which contracts are affected. 3. A description of the actions Kaiser will take to correct this deficiency. 4. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. 5. A robust and meaningful outreach effort plan to educate individuals about this change, ensuring that the information clear states that the individuals are not limited in any way to selecting only another Kaiser product. Outreach efforts should encourage each individual to review all options offered by employers/former employers in the decision making process. 6. Selection of one plan (one PBP serving each applicable area) into which all individuals from the STRS/PERS group will default if they have not selected another enrollment option. In other words, Kaiser may not distribute these individuals across various products within service areas. The ¿default¿ into an individual KPSA plan follows the requirements provided in section 50.7 (option 1) of the MA enrollment guidance with 2 key adjustments that must also be included in the CAP: a. Plans to provide information and a simple mechanism to decline enrollment, to provided no later than October 31, 2008, to ensure individuals are aware before the start of the AEP, and b. Notice to the individuals of an available SEP beginning on November 1, 2008 and ending on January 31, 2009, which is not limited to selecting only Kaiser products. 7. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place. 8. Notification and/or script to the members, including their submission for Regional Office review and approval.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO must ensure that notices are current and are compliant with the required language per Chapter 2 of the Medicare Managed Care Manual. MAO must make sure that older versions of the above mention notices are discarded to prevent erroneous versions from being printed and mailed to beneficiaries. MAO is required to ensure that all notices are approved or accepted through the HPMS marketing module.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 02 - Enrollment and Disenrollment		SDM must revise its policies and procedures to ensure that it adheres with CMS enrollment guidelines. Chapter 2 of the Medicare Managed Care Manual Section 40.2.2, states, when an incomplete enrollment election is received, the MAO must document all efforts to obtain additional documentation to complete the enrollment election and have an audit trail to document why the enrollment election needed additional documentation before it could be considered complete. The organization must make this determination and notify the individual within 10 calendar days of receipt of the request that additional information is needed for the enrollment request. For AEP elections, additional documentation to make the request complete must be received by December 31, or within 21 calendar days (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days (whichever is later).	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 02 - Enrollment and Disenrollment		In accordance with Chapter 2, of the Medicare Managed Care Manual Section 40.2.3, if an MAO determines that an individual is not eligible for enrollment in their MA Plan, the organization must send a notice of the denial to the individual that includes an explanation of the denial. This notice must be sent within ten calendar days of either 1) receipt of the enrollment request or 2) expiration of the time frame for receipt of requested additional information. SDM must update its policies and procedures to reflect the aforementioned requirements.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 02 - Enrollment and Disenrollment		SDM must revise its policy and procedures to reflect all requirements as outlined in Chapter 2 of the Medicare Managed Care Manual Section 50.2.1. At minimum, in the event SDM receives a notice of change of address from the member, the member¿s legal representative, a CMS transaction reply report, or another source it must make an attempt to contact the member to confirm whether the move is permanent and document its efforts. In the case of incarcerated individuals, SDM is not required to contact the individual but must confirm the individual¿s out-of-area (e.g. incarcerated) status. MA organizations may obtain either written or verbal verification of changes in address, as long as the MA organization applies the policy consistently among all members. The MA organization must retain documentation from the member or member¿s legal representative of the notice of the change in address, including the determination of whether the move out of the service area is temporary or permanent. In addition SDM must ensure that it adheres to the notice requirements as outlined in Section 50.2.1.4 of the manual.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 04 - Benefits and Beneficiary Protections		SDM is to develop a system of auditing and the performance of its delegated entity in all delegated function areas. SDM to perform periodic and annual audits as required by the regulations. SDM is to submit a plan to CMS showing how this will be accomplished.	Open

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 05 - Quality Assurance		SDM is to implement a system of formal monthly meeting of the committee responsible for UM until further notice from CMS reviewer. SDM is to submit the minutes of this Committee to CMS including data sufficient to explain the committee findings conclusions and actions. SDM is to develop and implement systems for collecting data regarding at risk physicians and for monitoring and evaluating the referral patterns of physicians at risk for services and utilization of services by patients of these physicians. SDM is to submit to CMS a document that identifies the coordinator of the UM program. This document is also to include the knowledge, qualifications, and experience of this person to perform this function.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 05 - Quality Assurance		SDM is to submit policies and procedures to show how it will audit the delegated functions of this delegated entity.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 06 - Provider Relations		SDM is to conduct training for all credentialing staff regarding the CMS credentialing requirements. SDM needs to develop a method to demonstrate that quality information regarding health care professionals is considered during the credentialing process. SDM is to conduct a review of its health care professional credentialing files and also perform periodic reviews thereafter to assure compliance with all requirements including verification of license and highest level of education for all health care professionals. SDM is to develop an action plan with a time schedule that shows how the credentialing of Entity B providers will be accomplished and completed. SDM is to conduct an audit of the credentialing functions of Delegated Entity B. Periodic and annual audits are also to be done thereafter. Where credentialing is to be conducted as a delegated function, SDM must submit a delegated entity credentialing contract for entity B and any other delegated credentialing entity for which no credentialing delegation contract exists.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		In accordance with Medicare Guidelines, SDM and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		SDM must ensure that performs routine compliance checks of its payment practices and that it uses the appropriate Medicare fee-for-service payment mechanisms when determining amounts to pay non-contracted providers. If the plan has negotiated lower amounts or if a provider bills lower amounts than is possible under fee-for-service, paying non-contracted providers these lower amounts is appropriate.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		In accordance with Medicare Guidelines, SDM and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		SDM must ensure it or its delegated entities pay all clean claims exceeding 30 days accordingly with the proper interest payment in accordance with the prevailing rate as published by the U.S. Treasury.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		In accordance with Medicare Guidelines, SDM and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		If SDM or it's designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The Standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		CMS auditor noted that SDM had the appropriate member notice approved but incorrect letters were used. SDM must establish a mechanism for ongoing monitoring of this area to ensure departments are utilizing the correct notices.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 01: Enrollment and Disenrollment		SDM must provide evidence of the following: request of beneficiary confirmation to continue enrollment, resubmission of enrollment to CMS, and a denial notice of the enrollment to demonstrate compliance with CMS requirements.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 03: Marketing and Beneficiary Information		WHI via SDM must provide CMS with a CMS approved or accepted notice for enrollee notification when a request is forwarded to the IRE consistent with CMS issued model notice, Notice of Case Status. If WHI does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, `Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. SDM must ensure that WHI has conducted training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 03: Marketing and Beneficiary Information		SDM must conduct training of appropriate staff on policy and procedure MR08 No Engagement in Activities Which Could Mislead, Confuse, or Misrepresent, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. SDM must conduct ongoing monitoring of the marketing activities of internal and external marketing representatives who are meeting with potential enrollees and confirm the marketing representatives complete the following: -identify the types of products the representatives will be discussing before they market the products to the enrollees, and -provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Once the enrollment freeze is lifted, SDM must provide documentation of these monitoring activities to CMS. SDM must include provisions within its marketing contracts/compensation structures requiring any person employed to perform marketing on behalf of SDM provide a written disclosure statement to all potential enrollees prior to or at the time of enrollment. The written disclosure statement must state the following: `The person discussing plan options with you is either employed by or contracted with SDM. The person may be compensated based on your enrollment in a plan', and provide documentation demonstrating this to CMS. Additionally, SDM must ensure that contract/compensation structures contain a provision stating that any marketing representative who is meeting with a potential enrollee must clearly identify the types of products that he or she will be discussing before marketing the products to the enrollee, and that any coordinated marketing must be conducted in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal Health Care Laws (including civil monetary penalty laws).	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 03: Marketing and Beneficiary Information		SDM must ensure that it mails Initial Post-Enrollment Information in a timely manner in accordance with CMS timeframes. SDM must also ensure that only material that has been approved by CMS is sent to enrollees. SDM must submit documentation demonstrating this to CMS.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 04: Privacy and Confidentiality		SDM submitted to the audit team a policy and procedure entitled `ED01.15 Use of Alias ID', dated post-audit period (April 1, 2008) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must ensure that WHI is instructing its pharmacy network to post or distribute the 'Medicare Prescription Drug Coverage and Your Rights' notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist as required by CMS and submit documentation demonstrating this to CMS.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must ensure that WHI, if applicable, and SDM provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified cases. Based on the analysis, SDM is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified cases. Based on the analysis, SDM is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified cases. Based on the analysis, SDM is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified cases. Based on the analysis, SDM is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified cases. Based on the analysis, SDM is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		If SDM fails to notify the enrollee of its coverage determination decision in a timely manner, SDM must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe using a notice consistent with the Notice of Case Status and provide documentation demonstrating this to CMS. SDM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified cases. Based on the analysis, SDM is to provide to CMS the root cause as well as a detailed corrective action plan.	Open
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified cases. Based on the analysis, SDM is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals		SDM must provide documentation to CMS demonstrating that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. SDM must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures and submit documentation demonstrating this to CMS. SDM must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. SDM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, SDM is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Ad-Hoc Compliance Event	6/13/2008	Open	Chapter 15: Policies and Procedures		SDM must revise its policies and procedures to include provisions as identified in each of the above listed element's Recommendation/Notes section.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 02 - Enrollment and Disenrollment		Aids Healthcare Foundation must describe the actions it is taking to ensure that it is meeting the requirements for Involuntary Disenrollments for non-payment of premiums in accordance with CMS policy and regulations. As part of the required corrective action, Aids Healthcare Foundation must revise its policies and procedures and describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 02 - Enrollment and Disenrollment		Aids Healthcare Foundation must describe the actions it is taking to ensure that it is meeting the member notification requirements for beneficiary moves out of the service area in accordance with CMS policy and regulations. Aids Healthcare Foundation must enhance the existing processes in place to ensure that members are notified timely of a proposed involuntary disenrollment when information received indicates that the beneficiary has moved out of the service area. As part of the required corrective action, Aids Healthcare Foundation must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 02 - Enrollment and Disenrollment		Aids Healthcare Foundation must revise its policies and procedures to include the requirements noted in the deficiency above. Aids Healthcare Foundation was aware of this error prior to the audit and has revised its policies and procedures to include these provisions and no additional corrective action is required.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 02 - Enrollment and Disenrollment		Aids Healthcare Foundation must describe the actions it is taking to ensure that it is meeting the member notification requirements for enrollments in accordance with CMS policy and regulations. As part of the required corrective action, Aids Healthcare Foundation must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 02 - Enrollment and Disenrollment		Aids Healthcare Foundation must describe the actions it is taking to ensure that it is meeting the member notification requirements for enrollments in accordance with CMS policy and regulations. As part of the required corrective action, Aids Healthcare Foundation must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 02 - Enrollment and Disenrollment		Aids Healthcare Foundation must revise its policies and procedures to include the requirements noted in the deficiency above and the appropriate notices must be submitted to CMS for their review and approval.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 04 - Benefits and Beneficiary Protections		AHF must submit to CMS a description of how its Medicare enrollees have received Medicare required chiropractic services since the initiation of its CMS contract. AHF must also submit to CMS its corrective action plan including a date certain for securing Medicare contracted chiropractors for its California Chronic Care SNP.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 11 - Contracts		AHF must ensure that its downstream provider contracts include the following CMS required language: "agree to audits and inspection by CMS and/or its designees, cooperate, assist, and provide information, as requested, and maintain records a minimum of 10 years." Submit to CMS the corrective action for amending the downstream provider contracts and date certain for its completion.	Open
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Aids Healthcare Foundation must describe the actions it is taking to ensure that it is meeting the member notification requirements for grievances in accordance with CMS policy and regulations. As part of the required corrective action, Aids Healthcare Foundation must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Aids Healthcare Foundation must send CMS compliant notices (the standardized Notice of Denial of Payment) to members when it denies claims from non-contracted providers. The description of denied services and the denial reasons used with the notice must be clear and understandable. Aids Healthcare Foundation was aware of the deficiency prior to the audit and has already been working on the Corrective Action Plan.	Closed
AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Describe actions AIDS Healthcare Foundation (AHF) is taking to ensure it is meeting the timeliness standards for standard pre-service organization determinations in accordance with CMS policy and regulations. The process must include internal health plan audits to ensure compliance with CMS requirements.	Open

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AIDS Healthcare Foundation	1-323-860-5202	H5852	MA	Audit Findings	6/5/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		AHF must submit to CMS a revised and corrected, UM 16.0-Determination and Notification Regarding Non-Coverage of Inpatient Hospital Care policy and procedure, flowchart and appropriate CMS notice for the Detailed Notice of Discharge of Inpatient Hospital Care process. The corrective action must include internal health plan audits to ensure compliance with CMS requirements.	Closed
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 02 - Enrollment and Disenrollment		Neighborhood Health Plan (NHP) must conduct training of appropriate marketing and enrollment staff on enrollment election procedures such as making corrections to an individual enrollment form, documenting the reason for corrections and the individual making the corrections. NHP must also submit documentation to the regional office that details the nature of this training including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 03 - Marketing		Neighborhood Health Plan (NHP) must develop and implement policies and procedures that incorporate the regulations and marketing guidelines for submission and distribution of File and Use materials. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 03 - Marketing		Neighborhood Health Plan (NHP) must establish and maintain effective oversight controls over its marketing department to ensure that State laws regarding license agents are followed. NHP must comply with NY State Insurance Law which states that an unlicensed employee of a licensed insurance broker that sells, solicits or negotiates insurance would be acting as an insurance broker and would need to be licensed as such. NHP must also maintain oversight control to prevent that an unlicensed employee to solicit, sell or negotiate insurance for a commission or other compensation directly dependent on the amount of business done. The MCO must submit a policy and procedure which describes the types of oversight activities it will implement over its delegated entities. NHP must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance. While onsite the plan supplied and updated state license for one marketing representative who had an expired license on file. This was satisfactory.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 06 - Provider Relations		NHP is to submit a corrective action plan that shows how it will monitor the credentialing process to ensure compliance with verification of these requirements at the time of credentialing.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 11 - Contracts		Neighborhood Health Providers (NHP) must ensure that all the contracts are amended to reflect the 10 years record retention requirements as states in the regulation 42 CFR 422.504. A copy of the amendment to the contracts, must be sent to CMS for review and NHP must ensure that all the network providers are aware of that requirements.	Closed
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Neighborhood Health Providers (NHP) must conduct training of appropriate staff on the CMS requirements to send member notices within the established timeframe. NHP must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Neighborhood Health Providers (NHP) must revise its oversight of its delegated entities by ensuring that the delegated entities are following appropriate plan's policies and procedures. Policies and procedures should be updated to reflect guidelines on appropriate claims development associated with non-contracted providers. NHP must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		NHP must develop a system for processing and notifying their member timely regarding adverse pre-service organization determinations. The Plan must use CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC. The notices must be sent to the member in a timely manner and must clearly state the service denied and the specific denial reasons. The notices should inform the members of their rights. NHP must document all oral and written requests. Member services and the staff involved in this process should be trained in policies and procedures.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		A system must be developed so that the notices are sent timely and the notices must clearly state the reasons for service denial. NHP must document all oral and written requests. They should document when they notify the member orally and in writing. The plan must also develop a log for expedited request and the documentation should be comprehensive. Member services and the staff involved in this process should be trained in the policies and procedures. Furthermore, NHP must establish and maintain effective oversight of its delegated entities in order to ascertain if they are adhering to the plan and CMS policies and procedures.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Neighborhood Health Providers (NHP) must develop and implement policies and procedures for Adverse Expedited Organization Determinations. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the Regional office that details the nature of this training, including: the materials used in the training. NHP must develop a template letter with a matrix clearly stating the reasons for denials. The notice must have complete appeals language.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		NHP must develop and implement policies and procedures for Organizational Determination extensions. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the Regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. NHP must develop an Organization Determination Extensions Notice/Template. The notice/template must include reasons for the delay, and informs the member of their right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		NHP must develop a notice/template for a decision not to Expedite an Organization Determination. NHP must develop and implement policies and procedures for not expediting organizational determinations. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		NHP must develop and implement policies and procedures for notifying members about favorable standard pre-service organization determination. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		NHP must use a CMS approved Detailed Notice of Discharge Inpatient Hospital Care notice/template. NHP must develop and implement policies and procedures for hospital discharges. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Neighborhood Health Providers (NHP) must revise its policies and procedures for favorable claims reconsideration to include process to send written notice of its determination to member. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, they should also develop an approved Member notice template.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Neighborhood Health Providers must revise its policies and procedures for Favorable Standard Pre-Service Reconsiderations to include process to send written notice of its determination to member. Neighborhood Health Providers must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, they should also have an approved Member notice template.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		NHP must revise its policies and procedures for requests for Expedited Reconsiderations to address the process to foward its adverse expedited determination to CMS' independent review entity. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained NHP must develop a: Template of member notice about decision whether to expedite. Template of member notice of favorable decision. Template of member notice upholding denial. Template of cover letter/document used in forwarding case to CMS IRE. entity	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The plan must develop a written notice template. The notice must provide examples of reasons for the decision not to expedite the reconsideration.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The plan must contact IRE (Maximus-The Center for Health Disputes Resolution) for information on processing third party reconsideration reversals. The plan must develop policies and procedures for effectuating IRE expedited reconsiderations reversals. The plan must conduct training for the appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA	Audit Findings	5/13/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The plan must develop a notice template for this element. The plan must revise its policies and procedures for reconsideration extensions. The plan must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	Open
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA-PD	Audit Findings	5/13/2008	Open	Chapter 01: Enrollment and Disenrollment		Neighborhood Health Providers must conduct training of appropriate staff on obtaining a confirmation of the intent to enroll from any individual who attempts to enroll in the MAPD plan(s), but whose enrollment is conditionally rejected by CMS, due to a detacted match indicating that the beneficiary may have existing employer or union drug coverage. NHP must submit this documentation to the regional office that details the nature of this training inlcuding: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA-PD	Audit Findings	5/13/2008	Open	Chapter 03: Marketing and Beneficiary Information		Neighborhood Health Providers must conduct training of appropriate staff to the adherence of Medicare formulary change requirements. Prior to removing a covered Part D drug, NHP must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the negative formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the FDA or removed from the market by the manufacturer, NHP must provide retrospective notice to the affected enrollees. NHP must submit documentation to the RO that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Brookdale University and Hospital	1-212-808-4775 Ext. 147	H3336	MA-PD	Audit Findings	5/13/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records		Neighborhood Health Providers (NHP) must revise its oversight of its delegated entities by ensuring that contracts (both the Provider Agreement and the Part D Addendum) are signed and dated by vendors. NHP must develop policies and procedures that specifically address this matter by stating that staff must ensure that both contacts are received by NHP, signed, and dated. NHP must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PIC must revise, and submit to the Regional Office for approval, the enrollee notification sent to confirm a voluntary disenrollment identified through a transaction reply report.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PIC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.74(d). The CAR should clearly describe the measures that PIC will undertake to ensure that an involuntary disenrollment action due to nonpayment of premiums is consistent with regulatory requirements and CMS manual instructions. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. The CAP should include a provision for ongoing monitoring of the various actions required for accurate processing of an involuntary disenrollment. Following corrective actions taken, PIC must conduct an internal audit of these actions, on a monthly basis, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. PIC must continue to provide a monthly update of internal audit results until CMS determines that PIC meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PIC must develop a member notice to be used for an involuntary disenrollment due to a permanent move outside of the service area to accurately convey the nature of the disenrollment action and submit the notice to the CMS Regional Office for approval prior to use.	Open

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Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PIC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.60(e) (3). The CAR should clearly describe the measures that PIC will undertake to ensure that enrollees are notified of receipt of an election and confirmation of enrollment within timeframes contained in the Medicare Managed Care Manual, Chapter 2, section 40.4 and 40.4.2. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. The CAP should include a provision for ongoing monitoring of the various actions required for accurate notification of an enrollment notice. Following corrective actions taken, PIC must conduct an internal audit of these actions, on a monthly basis, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit. PIC must continue to provide a monthly update of internal audit results until CMS determines that PIC meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PIC must revise, and submit to the Regional Office for approval, the beneficiary Welcome and Confirmation letters to ensure consistency with CMS requirements in the Medicare Managed Care Manual, Chapter 2, Exhibits 4 and 6.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PIC must revise, and submit to the Regional Office for approval, the denial of enrollment notice to ensure that information contained within is consistent with the Medicare Managed Care Manual, Chapter 2, Section 30.3	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PIC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.60 and sections 40.4.2 and 60.4 of the Medicare Managed Care Manual. The CAR should clearly describe the measures that PIC will undertake to ensure that, when appropriate, requests for retroactive enrollment actions are submitted to CMS contractor in a timely manner. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. The CAP should include a provision for ongoing monitoring of the various actions required for appropriate retroactive enrollment requests. Following corrective actions taken, PIC must conduct an internal audit of these actions, on a monthly basis, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit. PIC must continue to provide a monthly update of internal audit results until CMS determines that PIC meets regulatory requirements.	Open

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Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 06 - Provider Relations		PIC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.204. PIC must take appropriate steps to establish credentialing procedures that are consistent with regulatory requirements. The CAP should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. PIC must provide the format and content of revised policies and procedures and the CAP should include a provision for ongoing monitoring of this delegated function. Following corrective actions taken, PIC should conduct an internal audit on a monthly basis, of credentialing and recredentialing actions to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for submission of a monthly report to the Regional Office of the audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of auditor(s), the audit methodology, and the results of the audit. PIC must continue to provide monthly updates of internal audit results until CMS determines that PIC meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		PIC must revise, effectuate and audit internal procedures to ensure compliance with CFR 422.568(e). PIC must take appropriate steps to correct denial notices for noncontracting provider claims to ensure that notices to an enrollee provide a specific reason for the denial. In addition, in order to protect enrollee due process rights, PIC must identify all instances where members were not issued a claim denial notice within the last twelve months for services provided by a noncontracting provider and ensure that an appropriate member notice is provided in all instances. The CAP should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. PIC must provide the format and content of revised policies and procedures and the CAP should include a provision for ongoing monitoring. Following corrective actions taken, PIC should conduct an internal audit on a monthly basis, of claim denials from noncontracting providers issued by the organization to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for submission of a monthly report to the Regional Office of the audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of auditor(s), the audit methodology, and the results of the audit. PIC must continue to provide monthly updates of internal audit results until CMS determines that PIC meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		PIC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.568(e) as well as instructions in the Medicare Managed Care Manual, Chapter 13, section 40.2.2. PIC must take appropriate steps to ensure that the content of adverse standard pre-service organization determinations comply with regulatory requirements. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. In addition, the CAP should include a provision for ongoing monitoring. Following corrective actions taken, PIC should conduct an internal audit, on a monthly basis, of all adverse notices issued by the organization, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor (s), the audit methodology, and the results of the audit. PIC must continue to provide monthly updates of internal audit results until CMS determines that PIC meets regulatory requirements.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA	Audit Findings	5/12/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		PIC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.572(a). PIC must take appropriate steps to ensure that notice is provided to an enrollee of PICs favorable or adverse expedited organization determination. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. Following corrective actions taken, PIC should conduct an internal audit, on a monthly basis, of all expedited organization determinations to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings by the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. PIC must continue to provide the monthly update of internal audit results until CMS determines that PIC meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PHP must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.66(b)(3) and Medicare Managed Care Manual Chapter 2, Section 50.1.4. The CAR should clearly describe the measures that PHP will undertake to ensure that disenrollment notices are sent to the member within the timeframe that is consistent with regulatory requirements and CMS manual instructions. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. The CAP should include a provision for ongoing monitoring of the various actions required for timely distribution of written confirmation notices of disenrollment to the member within ten calendar days of the availability of the Transaction Reply Report (TRR). Following corrective actions taken, PHP must conduct an internal audit of these actions, on a monthly basis, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. PHP must continue to provide a monthly update of internal audit results until CMS determines that PHP meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PHP must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.74(d). The CAR should clearly describe the measures that PHP will undertake to ensure that an involuntary disenrollment action due to nonpayment of premiums is consistent with regulatory requirements and CMS manual instructions. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. The CAP should include a provision for ongoing monitoring of the various actions required for accurate processing of an involuntary disenrollment. Following corrective actions taken, PHP must conduct an internal audit of these actions, on a monthly basis, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. PHP must continue to provide a monthly update of internal audit results until CMS determines that PHP meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PHP must develop a beneficiary notice to be used for an involuntary disenrollment due to a permanent move outside of the service area to accurately convey the nature of the disenrollment action and submit the notice to the CMS Regional Office for approval prior to use.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PHP must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.60(e) and Medicare Managed Care Manual Chapter 2, Section 40.2.2. The CAR should clearly describe the measures that PHP will undertake to ensure that incomplete enrollment elections are identified and that information to complete the election is requested of the beneficiary. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. The CAP should include a provision for ongoing monitoring of the various actions required for accurate identification of an incomplete enrollment. Following corrective actions taken, PHP must conduct an internal audit of these actions, on a monthly basis, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit. PHP must continue to provide a monthly update of internal audit results until CMS determines that PHP meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PHP must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.60(e) (3) and Medicare Managed Care Manual Chapter 2, Section 40.4, 40.4.2. The CAR should clearly describe the measures that PHP will undertake to ensure that enrollees are notified of receipt of an election and confirmation of enrollment within timeframes contained in the Medicare Managed Care Manual, Chapter 2, section 40.4 and 40.4.2. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. The CAP should include a provision for ongoing monitoring of the various actions required for accurate notification of an enrollment notice. Following corrective actions taken, PHP must conduct an internal audit of these actions, on a monthly basis, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit. PHP must continue to provide a monthly update of internal audit results until CMS determines that PHP meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PIC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.60(e) (3) and Medicare Managed Care Manual Chapter 2, Section 40.2.3. The CAR should clearly describe the measures that PIC will undertake to correctly notify beneficiaries of denial of enrollment within timeframes specified by CMS. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. The CAP should include a provision for ongoing monitoring of the various actions required for accurate identification of an enrollment denials. Following corrective actions taken, PHP must conduct an internal audit of these actions, on a monthly basis, to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings on or before the 20th of the following month and subsequent months. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit. PHP must continue to provide a monthly update of internal audit results until CMS determines that PHP meets regulatory requirement.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA	Audit Findings	5/12/2008	Open	Chapter 02 - Enrollment and Disenrollment		PHP must revise and submit to the Regional Office, for approval, the denial of enrollment notice to ensure that information contained within is consistent with the Medicare Managed Care Manual, Chapter 2, Section 30.3.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA	Audit Findings	5/12/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		PHP must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.572(a). PHP must take appropriate steps to ensure that notice is provided to an enrollee of PHPs favorable or adverse expedited organization determination. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. Following corrective actions taken, PHP should conduct an internal audit, on a monthly basis, of all expedited organization determinations to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a monthly summary report to the Regional Office of the monthly audit findings by the 20th of the following month. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. PHP must continue to provide the monthly update of internal audit results until CMS determines that PHP meets regulatory requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA-PD	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must conduct training of appropriate staff and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of enrollment for members of Employer-Union Groups and submit the results to CMS through HPMS to see if staff obtains confirmation from the beneficiary within the 10 calendar days of the receipt of the reply listing with initial CMS rejection of enrollment. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3204	MA-PD	Audit Findings	5/10/2008	Open	Chapter 15: Policies and Procedures		For each of the elements listed in the deficiency section, the Part D sponsor must revise its policies and procedures to include the provisions listed. When revised and approved by appropriate staff, submit a copy to CMS. CMS guidance for the required provisions can be found at: ER09 - 42 CFR 423.34(d), PDP Solicitation-Section 3.5, PDP-EED-Chapter 3-Section 30.1.4. ER13 - PDP-EED-Chapter 3-Sections 20.3.8, 20.4, and 20.5. MR09 - MMG-Section 6. PR02 - PDP and MA-PD Solicitations. FM03 - MMG-Section 6, Prescription Drug Benefit Manual-Chapter 6-Section 30.3. The sponsor must conduct training on the revised policies and procedures to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA-PD	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must conduct training of this policy for appropriate staff and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct monthly audits of enrollment for members of Employer-Union Groups to see if staff obtains confirmation from the beneficiary within the 10 calendar days of the receipt of the reply listing with initial CMS rejection of enrollment. The sponsor needs to submit the audit results to CMS monthly. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Presbyterian Healthcare Services	1-505-923-8955	H3206	MA-PD	Audit Findings	5/10/2008	Open	Chapter 15: Policies and Procedures		For each of the elements listed in the deficiency section, the Part D sponsor must revise its policies and procedures to include the provisions listed. When revised and approved by appropriate staff, submit a copy to CMS. CMS guidance for the required provisions can be found at: ER09 - 42 CFR 423.34(d), PDP Solicitation-Section 3.5, PDP-EED-Chapter 3-Section 30.1.4. ER13 - PDP-EED-Chapter 3-Sections 20.3.8, 20.4, and 20.5. MR09 - MMG-Section 6. PR02 - PDP and MA-PD Solicitations. FM03 - MMG-Section 6, Prescription Drug Benefit Manual-Chapter 6-Section 30.3. The sponsor must conduct training on the revised policies and procedures to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		Managers need to discuss with staff the proper notices to use for disenrollments. The Part D sponsor must conduct training of appropriate staff on its policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of disenrollments to see if staff are applying the regulations and CMS policies, and to determine if the proper notice is issued. The audit results need to be submitted to CMS through HPMS. The sponsor must provide a detailed description of how it will ensure these requirements are met.	Open
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must implement and conduct training on internal procedures and CMS policies. Submit to CMS documentation that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of disenrollments for death of individuals to see if staff are following regulations and CMS policies, i.e. issuing the correct notice to the members estate, confirming disenrollment date is correct in internal system and CMS system, and all other appropriate steps. Submit the monthly audit results to CMS through HPMS. The sponsor must provide a detailed description of how it will ensure ongoing compliance with these requirements.	Open
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must revise, implement, and train on its internal policies to assure it is following the CMS policy for transmitting disenrollments to CMS appropriately. The sponsor must conduct training to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of disenrollment tranmissions to observe if staff are following the policy and procedures in a timely manner. The sponsor needs to submit the results of the monthly audits to CMS through HPMS. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must conduct training of the CMS policy to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of incomplete enrollments to see if staff is following the policy and attempting to obtain the missing information within 10 calendar days of the receipt of the enrollment request. The sponsor needs to submit the results of the monthly audits to CMS through HPMS. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Open
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must conduct training of the CMS policy to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of applications and enrollment requests to see if staff is following the policy and providing the cancellation notice to the individual within 10 calendar days of the receipt of the cancellation request. The sponsor needs to submit the results of the monthly audits to CMS through HPMS. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Open
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must conduct training of the CMS policy to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of enrollments for members of Employer/Union Groups to see if staff is following the policy by sending the EOC to the member on the same date the sponsor sends the Final Acceptance Notice to the member. The sponsor needs to submit the results of the monthly audits to CMS through HPMS. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Open
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must conduct training of the CMS policy to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of applications and enrollment requests to see if staff is following the policy by sending the new member materials prior to the effective date of enrollment, or within 10 calendar days of the Part D sponsors receipt of the complete enrollment request. The sponsor needs to submit the results of the monthly audits to CMS through HPMS. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 01: Enrollment and Disenrollment		The Part D sponsor must conduct training of the CMS policy to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained. Beginning June 1, the sponsor needs to conduct an internal audit of applications and enrollment requests to see if staff are following the policy by transmitting the enrollment transaction to CMS within seven calendar days of the sponsors receipt of the complete enrollment request. The sponsor needs to submit the results of the monthly audits to CMS through HPMS. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Open
Presbyterian Healthcare Services	1-505-923-8955	S5902	Part D	Audit Findings	5/10/2008	Open	Chapter 15: Policies and Procedures		For each of the elements listed in the deficiency section, the Part D sponsor must revise its policies and procedures to include the provisions listed. When revised and approved by appropriate staff, submit a copy to CMS. CMS guidance for the required provisions can be found at: ER01 - 42 CFR 423.32(b), PDP Guidance Eligibility, Enrollment and Disenrollment (PDP-EED)-Chapter 3-Section 30.1.3. ER06 - 42 CFR 423.32(d), PDP Solicitation-Section 3.5, PDP-EED-Chapter 3-Section 30.4.1, Medicare Marketing Guidelines (MMG)-Section 7. ER08 - PDP Solicitation-Section 3.5, PDP-EED-Chapter 3-Section 30.4.1, MMG, Section 7. ER09 - 42 CFR 423.34(d), PDP Solicitation-Section 3.5, PDP-EED-Chapter 3-Section 30.1.4. ER13 - PDP-EED-Chapter 3-Sections 20.3.8, 20.4, and 20.5. DN12 - 42 CFR 423.36(b)(1), PDP-EED-Chapter 3-Section 40.4.1. MR09 - MMG-Section 6. PR02 - PDP and MA-PD Solicitations. FM03 - MMG-Section 6, Prescription Drug Benefit Manual-Chapter 6-Section 30.3. The sponsor must conduct training on the revised policies and procedures to appropriate staff and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Ad-Hoc Compliance Event	4/17/2008	Closed	Chapter 02 - Enrollment and Disenrollment		The CAP should address the following information: 1. Kaiser needs to revise its Policy and Procedures for handling Employer Group Terminations. The Policy and Procedures need to state that Kaiser will review the marketing materials that the Employer Group and Kaiser send to the beneficiary to ensure that they are clear concise and not confusing to the member. 2. Regarding California and Ohio GM members still enrolled in Kaiser who took no action in response to December or January correspondence, Kaiser needs to work closely with GM to send these members a CMS approved letter stating that they are currently enrolled in the Kaiser DPA plan and what process to follow if they want to be disenrolled. Kaiser needs to contact those members who fail to respond with a CMS approved script. 3. Include a description of the actions Kaiser will take to correct this deficiency. 4. Include a timetable showing when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. 5. Include a description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Kaiser Foundation Health Plan, Inc.	1-303-344-7758	H0630	MA	Ad-Hoc Compliance Event	4/17/2008	Closed	Chapter 02 - Enrollment and Disenrollment		The CAP should address the following information: 1. Kaiser needs to revise its Policy and Procedures for handling Employer Group Terminations. The Policy and Procedures need to state that Kaiser will review the marketing materials that the Employer Group and Kaiser send to the beneficiary to ensure that they are clear concise and not confusing to the member. 2. Regarding California and Ohio GM members still enrolled in Kaiser who took no action in response to December or January correspondence, Kaiser needs to work closely with GM to send these members a CMS approved letter stating that they are currently enrolled in the Kaiser DPA plan and what process to follow if they want to be disenrolled. Kaiser needs to contact those members who fail to respond with a CMS approved script. 3. Include a description of the actions Kaiser will take to correct this deficiency. 4. Include a timetable showing when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. 5. Include a description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-404-364-4923	H1170	MA	Ad-Hoc Compliance Event	4/17/2008	Closed	Chapter 02 - Enrollment and Disenrollment		The CAP should address the following information: 1. Kaiser needs to revise its Policy and Procedures for handling Employer Group Terminations. The Policy and Procedures need to state that Kaiser will review the marketing materials that the Employer Group and Kaiser send to the beneficiary to ensure that they are clear concise and not confusing to the member. 2. Regarding California and Ohio GM members still enrolled in Kaiser who took no action in response to December or January correspondence, Kaiser needs to work closely with GM to send these members a CMS approved letter stating that they are currently enrolled in the Kaiser DPA plan and what process to follow if they want to be disenrolled. Kaiser needs to contact those members who fail to respond with a CMS approved script. 3. Include a description of the actions Kaiser will take to correct this deficiency. 4. Include a timetable showing when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. 5. Include a description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-216-479-5694	H6360	MA	Ad-Hoc Compliance Event	4/17/2008	Closed	Chapter 02 - Enrollment and Disenrollment		The CAP should address the following information: 1. Kaiser needs to revise its Policy and Procedures for handling Employer Group Terminations. The Policy and Procedures need to state that Kaiser will review the marketing materials that the Employer Group and Kaiser send to the beneficiary to ensure that they are clear concise and not confusing to the member. 2. Regarding California and Ohio GM members still enrolled in Kaiser who took no action in response to December or January correspondence, Kaiser needs to work closely with GM to send these members a CMS approved letter stating that they are currently enrolled in the Kaiser DPA plan and what process to follow if they want to be disenrolled. Kaiser needs to contact those members who fail to respond with a CMS approved script. 3. Include a description of the actions Kaiser will take to correct this deficiency. 4. Include a timetable showing when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. 5. Include a description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		As stated in Chp. 2 Section 50.1.4 - If the MA organization learns of the voluntary disenrollment from the CMS transaction reply report (as opposed to through written request from the member), the MA organization must send a written confirmation notice of the disenrollment to the member within seven business days of the availability of the transaction reply report. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must disenroll Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than six (6) months, unless they move into an approved plan continuation area and the member has elected the continuation of enrollment option, or the plan offers a visitor/traveler program. Member notice is required prior to transmission of the disenrollment to CMS. Please submit the universe for the last six months.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		AEP info needs to be updated to reflect current year (letter currently states 2006).	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must correctly notify beneficiaries of denial of enrollment within timeframes specified by CMS. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		Denial letter AEP dates needs to be updated to reflect current year (letter currently states 2006) - to meet CMS requirements. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		The MAO must review the CMS Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follow-up on any notification of a potential change in residence for its members reported to it by CMS. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 02 - Enrollment and Disenrollment		MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 03 - Marketing		MAO has constructed new policies and procedures for 2008 however they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 03 - Marketing		MAO has constructed new policies and procedures for 2008 however, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures effective date, to us electronically for our review.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 06 - Provider Relations		The MAO must submit a plan to ensure credentialing and recredentialing files are in compliance with regulations and are maintained to ensure files remain current. The MAO must submit a plan to provide oversight of delegated credentialing entities and a plan to ensure delegated credentialing files are in compliance with federal regualtions. Submit title of person who will monitor for compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 11 - Contracts		The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for safeguarding beneficiary privacy and confidentiality. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 11 - Contracts		The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for a prompt payment provision. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 11 - Contracts		The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 11 - Contracts		The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for reporting, audits, inspection by CMS or its designees, cooperation, and maintainence of records for a minimum of 10 years. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 11 - Contracts		The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for providers to comply with the MAO's policies and procedures. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must conduct training of appropriate staff to ensure required grievance notifications are sent to members within required timeframes. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must conduct training of appropriate staff to ensure required grievance notifications are sent to members when appropriate. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must conduct training of appropriate staff to ensure required grievance notifications are sent to members when appropriate. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		In accordance with Medicare Guidelines, Liberty must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation. Liberty must conduct appropriate training of its staff in the correct method for processing and documenting these claims. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Liberty needs to revise policy and procedure to include a definition for urgently needed services. Liberty must conduct monthly monitoring audits of this area submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its existing policies to include information on identifying handling clean and non-clean claims. The policy must include a step by step procedure for handling and processing received claims from non-contracted providers and the required timeframes. These policies must be approved and signed by appropriate officials. Liberty must conduct training for the appropriate staff and departments on these updated policies and procedures to ensure there is coordination of these processes within the plan. Documentation must be provided to the Regional Office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individual being trained. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Liberty should conduct a monthly internal audit of its claims determination. This audit should evaluate whether Liberty is paying its non-contracting provider clean claims timely. Liberty should submit a summary report once a quarter to the regional office of its monthly findings until further notice. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its existing policies to include information on identifying and how to handle clean and non-clean claims and to ensure that payment of interest is done for all claims over 30 days . The policy must include a step by step procedure for handling and, include information on processing those claims from non-contracted providers over 30 days within the required timeframes. Liberty must conduct training for the appropriate staff and departments on these updated policies and procedures to ensure there is coordination of these processes within the plan. Liberty will be required to submit Documentation to the Regional Office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individual being trained. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance, and Liberty should conduct a monthly internal audit to ensure interest is being paid on all late claims. This audit should evaluate whether Liberty is paying its non-contracting provider interest on late claims timely and the correct amount. Liberty should submit a summary report once a quarter to the regional office of its monthly findings until further notice. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		If Liberty or its designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The Standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any. Liberty must conduct appropriate training of its staff in the correct method for processing and documenting how requests for services are processed. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Liberty must conduct monthly monitoring audits of this area and submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must provide evidence of a formalized system for receiving and documenting expedited organization determinations requests from members. The policy must be updated to include the formalized system, a description of how the request is handled, and all departments and parties who are responsible for receiving, processing and expediting these requests to ensure requests are handled timely. This must also include copies of the notices approved through CMS process which will be sent to members. Policies must be approved and signed. Liberty must conduct training to staff on the updated guidelines and provide documentation to the regional office that details the nature of this training,the materials used in the training and the individual conducting the training.	Open

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Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must provide evidence of a formalized system for receiving, documenting and handling adverse expedited organization determinations requests from member to ensure denial notices with appeals rights etc. are sent timely to members. The updated policy must include a formalized process, timeframes to ensure that the request is handled, and all designated departments and parties involved in processing, expediting these requests and responsible for sending the notices timely to members. Policies must be approved and signed. Liberty must conduct training to staff on these updated guidelines and provide documentation to the regional office that details the nature of this training,the materials used in the training and the individual conducting the training.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		The plan must revise its policy to meet the requirements of the Medicare Managed Care Manual, Chapter 13, with respect to the denial notice of discharge of inpatient hospital care. The policy must be approved and signed. Liberty must conduct training to staff on these updated guidelines and provide documentation to the regional office that details the nature of this training,the materials used in the training and the individual conducting the training.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy so it is clear when a Favorable Claims Reconsideration is being addressed and when a Favorable Standard Pre-Service is being addressed. This policy must also include in its process all parties and department who are responsible for performing this functions and the required timeframes and template of the written notice sent to members with notification of the result - Please see Chapter 13 of the Medicare Managed Care Manual- sections 70.7.1 and 70.7.3 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on whether Favorable claims reconsiderations are received and handled appropriately and timely by the plan. Liberty should also determine whether it is correctly distinguishing between Favorable standard Pre-service reconsiderations and favorable claims reconsiderations. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open

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Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy so it is clear on its process for addressing Adverse Claims reconsiderations timely. This policy must also include in its process all parties and department who are resposible for performing this functions and the required timeframes and template of the written notice sent to members with notification of the result - Please see Chapter 13 of the Medicare Managed Care Manual- sections 70.7.1 and 70.7.3 for guidance. The Policy must be approved and signed, and all notices must be approved through HPMS according to CMS guidelines. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on whether adverse claims reconsiderations are received and handled appropriately and timely by the plan. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy so it is clear on its process for addressing the Effectuation of Third- Party Claims Reconsideration reversals. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes. This should include templates sent to the independent review entity that it has effectuated the decision - Please see Chapter 13 of the Medicare Managed Care Manual- section 140 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy so it is clear on its process for acceptance of standard reconsideration requests and must correct the information stated as being the start time for the appeal. This policy must also include in its process how it will handle oral requests, and all parties and department who are resposible for performing these functions and the required timeframes. Please see Chapter 13 of the Medicare Managed Care Manual- section 70 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty must conduct an internal audit each month of its incoming calls to ensure that they are properly categorized. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open

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Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy to outline its process for review of a reconsideration by the appropriate person (s). The information provided must be clear about who is conducting the review. The policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy so it is clear when a Favorable Claims Reconsideration is being addressed and when a Favorable Standard Pre-Service reconsideration is being addressed. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes, information regarding a fourteen day extension if justified, and a template of the written notice sent to members with notification of the result - Please see Chapter 13 of the Medicare Managed Care Manual- sections 70.7.1 and 70.7.3 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on whether favorable standard pre-service reconsiderations are received and handled appropriately and timely. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must clarify its policy for addressing Adverse Standard Pre-Service reconsiderations timely. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes and template of the written notice sent to members with notification of the result - Please see Chapter 13 of the Medicare Managed Care Manual- sections 70.7.1 and 70.7.3, 70.7.4 and 140 for guidance. The Policy must be approved and signed, and all notices must be approved through HPMS according to CMS guidelines. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on whether adverse standard pre-service reconsiderations are received and handled appropriately and timely. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open

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Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must clarify its policy for addressing the Effectuation of Third- Party Standard Pre-Service Reconsideration reversals under Medicare guidelines. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes. This should include templates which will be sent to the independent review entity when it has effectuated the decision - Please see Chapter 13 of the Medicare Managed Care Manual- section 140 for guidance. The Policy must be approved and signed. Please remove the information regarding charging the enrollee up to $50.00 per external appeal from the policy. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on the Effectuation of Third- Party Standard Pre-Service Reconsideration reversals. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must clarify its policy for receipt and documentation of Expedited reconsideration requests. This policy must also include in its process how it will handle all expedited reconsideration requests, and all parties and departments who are resposible for performing these functions and the required timeframes. Please see Chapter 13 of the Medicare Managed Care Manual- section 80.1 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy so its process is clear how requests for expedited reconsiderations are handled timely. This process must include the responsible persons and departments who are responsible for performing the various functions with required timeframes, and the process if the MAO decides not to expedite a reconsideration - Please see Chapter 13 of the Medicare Managed Care Manual- section 80.1 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty must establish a mechanism for ongoing monitoring of this area to ensure compliance. Liberty should complete an internal audit each month of its incoming calls for grievances and appeals. This audit should evaluate whether all calls are correctly classified and handled appropriately within CMS designated time frames. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must clarify its policy to include a step by step process of how requests for expedited reconsiderations are handled, who makes the decisions, based on the decision how members are advised of their rights to resubmit a request for an expedited reconsideration, as well as, information concerning the grievance process and timeframes, and who is responsible for sending the notices to members. The templates for these notices must also be included. - Please see Chapter 13 of the Medicare Managed Care Manual- section 80 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should complete an internal audit each month of how denied expedited reconsideration are handled when transfer to a standard reconsideration. This audit should evaluate whether members are informed of their appeals rights and if the written notices are sent timely. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy so it is clear on its process for addressing the Effectuation of Third- Party Expedited Reconsideration under Medicare guidelines. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes. This should include templates sent to the independent review entity that it has effectuated the decision - Please see Chapter 13 of the Medicare Managed Care Manual- section 140 for guidance. The Policy must be approved and signed. Please explain the information regarding charging the enrollee up to $50.00 per external appeal. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.	Open
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA	Audit Findings	4/7/2008	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals		Liberty must update its policy to include a process on how extensions are granted for all types of reconsiderations, and must include information concerning the member's right to file an expedited grievance if he/she disagrees with the decision to grant an extension- See Chapter 13 of the Medicare Managed Care manual - 70.7.1. The policy must be signed and approved. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.	Closed
Liberty Health Advantage, Inc.	1-631-227-3413	H3337	MA-PD	Audit Findings	4/7/2008	Open	Chapter 03: Marketing and Beneficiary Information		The MAO must submit a plan that demonstates that the neceassary demographic analysis is being performed to comply with CMS guidance, regulations and CMS Marketing Guidelines for non-English speaking populations. The MAO must submit a plan for marketing material submission and mailing to non - English speaking polulations that is in compliance with CMS Marketing Guidelines. The MAO will submit the title of the person who will monitor for compliance.	Open

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Wellpoint, Inc.	1-303-831-2514	S5596	Part D	Ad-Hoc Compliance Event	4/3/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is being sent by the Centers for Medicare and Medicaid Services because of compliance problems that have occurred as part of WellPoint' s operation (through several of its subsidiary organizations) of its Medicare Advantage Prescription Drug (MA-PD) contracts and Prescription Drug Plan (PDP) contracts: H0540, H0564, HI5II, H1607, H1689, H1849, H2613, H3655, H4909, H5304, H5419, H5422, H5529, H5530, H5679, H5842, R5941, R9943, S5596, S5960, S2893. Specifically, WellPoint has acknowledged its failure to properly administer the Low Income Subsidy (LIS) benefit and its failure to implement the required Explanation of Benefits (EOB) transfer process. Due to these failures, CMS is requesting that WellPoint submit a Corrective Action Plan (CAP) to address these two compliance violations. Failure to Properly Administer the LIS Benefit Pursuant to 42 CFR § 423.800(b) and (c), for beneficiaries who qualify for the LIS benefit, Part D plan sponsors are required to reduce the "individual's premiums and cost-sharing as applicable" and "reimburse subsidy eligible individuals, and organizations paying cost-sharing on behalf of such individuals, any excess premiums and cost-sharing paid by such individual or organization." During 2007 WellPoint did not properly apply the LIS benefit as required by this regulation for contracts H0540, H0564, H1689, H2613, H5304, H5419, H5422, H5679, R9943, S5596, S5960. WellPoint has acknowledged in communication with CMS since the spring of 2007 that it has overcharged an unknown number of LIS eligible beneficiaries and undercharged another unknown number of LIS beneficiaries due to its failure to properly administer the LIS benefit. Despite CMS' request for definitive details about this issue starting in the spring of 2007, to date WellPoint has failed to provide CMS with accurate details about the scope of this error. WellPoint has previously reported that this issue involves more than $13,000,000 in overpayments made by LIS beneficiaries to WellPoint which have not been reimbursed to the beneficiaries and approximately $800,000 in undercharges to LIS beneficiaries which have not yet been collected or billed. However, WellPoint has subsequently stated that its estimate is wrong and that it does not currently have new figures regarding this problem. This compliance violation is especially egregious because it involves a significant monetary impact on LIS beneficiaries, which CMS considers a particularly vulnerable segment of the Medicare beneficiary population. Failure to Implement the Required EOn Transfer Process Pursuant to 42 CFR § 423.464(f), Part D sponsors are obligated to coordinate benefits with other entities that provide prescription drug coverage, including other Part D sponsors. As part of the coordination of benefits, Part D sponsors must provide and accept transfer EOBs, as applicable,	Open

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									for beneficiaries who change Part D plans. These requirements are detailed in section 50.9 of Chapter 14 (Coordination of Benefits) of the Medicare Prescription Drug Manual. Despite WellPoint's recent acknowledgement that it was aware of this requirement since the inception of the program in 2006, WellPoint currently has no process in place for any of its Part D contracts for providing or accepting transfer EOBs. WellPoint's failure to establish a process for sending or receiving transfer EOBs has a direct impact on a beneficiary's ability to obtain year-to-date True Out of Pocket (TrOOP) Cost and Gross Covered Drug Cost (GCDC) balances. WellPoint's failure to comply with this requirement has also directly impeded other Part D sponsors' ability to appropriately administer the Part D benefit to enrolled beneficiaries. WellPoint's explanation that "plan programming and resources to operationalize this process were not dedicated at the time the Part D program was implemented in 2006" is not a satisfactory justification for violating this requirement.	

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Wellpoint, Inc.	1-303-831-2514	S5960	Part D	Ad-Hoc Compliance Event	4/3/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is being sent by the Centers for Medicare and Medicaid Services because of compliance problems that have occurred as part of WellPoint' s operation (through several of its subsidiary organizations) of its Medicare Advantage Prescription Drug (MA-PD) contracts and Prescription Drug Plan (PDP) contracts: H0540, H0564, HI5II, H1607, H1689, H1849, H2613, H3655, H4909, H5304, H5419, H5422, H5529, H5530, H5679, H5842, R5941, R9943, S5596, S5960, S2893. Specifically, WellPoint has acknowledged its failure to properly administer the Low Income Subsidy (LIS) benefit and its failure to implement the required Explanation of Benefits (EOB) transfer process. Due to these failures, CMS is requesting that WellPoint submit a Corrective Action Plan (CAP) to address these two compliance violations. Failure to Properly Administer the LIS Benefit Pursuant to 42 CFR § 423.800(b) and (c), for beneficiaries who qualify for the LIS benefit, Part D plan sponsors are required to reduce the "individual's premiums and cost-sharing as applicable" and "reimburse subsidy eligible individuals, and organizations paying cost-sharing on behalf of such individuals, any excess premiums and cost-sharing paid by such individual or organization." During 2007 WellPoint did not properly apply the LIS benefit as required by this regulation for contracts H0540, H0564, H1689, H2613, H5304, H5419, H5422, H5679, R9943, S5596, S5960. WellPoint has acknowledged in communication with CMS since the spring of 2007 that it has overcharged an unknown number of LIS eligible beneficiaries and undercharged another unknown number of LIS beneficiaries due to its failure to properly administer the LIS benefit. Despite CMS' request for definitive details about this issue starting in the spring of 2007, to date WellPoint has failed to provide CMS with accurate details about the scope of this error. WellPoint has previously reported that this issue involves more than $13,000,000 in overpayments made by LIS beneficiaries to WellPoint which have not been reimbursed to the beneficiaries and approximately $800,000 in undercharges to LIS beneficiaries which have not yet been collected or billed. However, WellPoint has subsequently stated that its estimate is wrong and that it does not currently have new figures regarding this problem. This compliance violation is especially egregious because it involves a significant monetary impact on LIS beneficiaries, which CMS considers a particularly vulnerable segment of the Medicare beneficiary population. Failure to Implement the Required EOn Transfer Process Pursuant to 42 CFR § 423.464(f), Part D sponsors are obligated to coordinate benefits with other entities that provide prescription drug coverage, including other Part D sponsors. As part of the coordination of benefits, Part D sponsors must provide and accept transfer EOBs, as applicable,	Open

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Wellpoint, Inc.	1-303-831-2514	S2893	Part D	Ad-Hoc Compliance Event	4/3/2008	Open	Chapter 99: Ad Hoc Compliance Event		This letter is being sent by the Centers for Medicare and Medicaid Services because of compliance problems that have occurred as part of WellPoint' s operation (through several of its subsidiary organizations) of its Medicare Advantage Prescription Drug (MA-PD) contracts and Prescription Drug Plan (PDP) contracts: H0540, H0564, HI5II, H1607, H1689, H1849, H2613, H3655, H4909, H5304, H5419, H5422, H5529, H5530, H5679, H5842, R5941, R9943, S5596, S5960, S2893. Specifically, WellPoint has acknowledged its failure to properly administer the Low Income Subsidy (LIS) benefit and its failure to implement the required Explanation of Benefits (EOB) transfer process. Due to these failures, CMS is requesting that WellPoint submit a Corrective Action Plan (CAP) to address these two compliance violations. Failure to Properly Administer the LIS Benefit Pursuant to 42 CFR § 423.800(b) and (c), for beneficiaries who qualify for the LIS benefit, Part D plan sponsors are required to reduce the "individual's premiums and cost-sharing as applicable" and "reimburse subsidy eligible individuals, and organizations paying cost-sharing on behalf of such individuals, any excess premiums and cost-sharing paid by such individual or organization." During 2007 WellPoint did not properly apply the LIS benefit as required by this regulation for contracts H0540, H0564, H1689, H2613, H5304, H5419, H5422, H5679, R9943, S5596, S5960. WellPoint has acknowledged in communication with CMS since the spring of 2007 that it has overcharged an unknown number of LIS eligible beneficiaries and undercharged another unknown number of LIS beneficiaries due to its failure to properly administer the LIS benefit. Despite CMS' request for definitive details about this issue starting in the spring of 2007, to date WellPoint has failed to provide CMS with accurate details about the scope of this error. WellPoint has previously reported that this issue involves more than $13,000,000 in overpayments made by LIS beneficiaries to WellPoint which have not been reimbursed to the beneficiaries and approximately $800,000 in undercharges to LIS beneficiaries which have not yet been collected or billed. However, WellPoint has subsequently stated that its estimate is wrong and that it does not currently have new figures regarding this problem. This compliance violation is especially egregious because it involves a significant monetary impact on LIS beneficiaries, which CMS considers a particularly vulnerable segment of the Medicare beneficiary population. Failure to Implement the Required EOn Transfer Process Pursuant to 42 CFR § 423.464(f), Part D sponsors are obligated to coordinate benefits with other entities that provide prescription drug coverage, including other Part D sponsors. As part of the coordination of benefits, Part D sponsors must provide and accept transfer EOBs, as applicable,	Open

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CVS Caremark Corporation	1-847-559-4714	S5601	Part D	Ad-Hoc Compliance Event	4/1/2008	Closed	Chapter 99: Ad Hoc Compliance Event		As of April 1, 2008 the records of the Centers for Medicare and Medicaid Services (CMS) indicate that SilverScript Insurance Co., which operates Medicare prescription drug plan (PDP) sponsor contract S5601, does not hold a license as a risk bearing entity in the following state(s): California New Jersey Oregon Rhode Island Vermont Wyoming In 2005, CMS issued your organization a three-year waiver (effective January 1, 2006) of the state licensure requirements for the identified state(s) in response to your application and pursuant to CMS¿ authority at 42 C.F.R. §423.410. The licensure waivers expire on December 31, 2008. Once the licensure waivers expire, unless it is licensed as a risk bearing entity in that state, your organization will no longer qualify to operate as a PDP sponsor in the states for which CMS granted the waivers. (42 C.F.R. §423.401(a)) As a result, CMS would non-renew your organization¿s contract (or reduce the contract¿s service area if your organization still has sufficient licenses or unexpired waivers to operate in at least one PDP region) pursuant to 42 C.F.R. §423.507(b)(i) and §423.509(a)(3). CMS must issue its PDP sponsor contract non-renewal notices on or before August 1, 2008 for an effective date of December 31, 2008. (42 C.F.R. §423.507(b)(2)(i)) Therefore, if your organization does not submit to CMS on or before July 31, 2008 documentation that it has obtained the required licenses, contract S5601 will be non-renewed for the 2009 contract year for any PDP regions that include states for which licensure documentation has not been received. Pursuant to 42 CFR §423.507(b)(3), this letter serves as notification that your organization may submit a corrective action plan (CAP) outlining how it will meet the state licensure requirement for the 2009 plan year by July 31, 2008. Please note that your organization should not view the CAP submission as an opportunity to seek CMS approval of an extension of the July 31, 2008 deadline for submitting licensure documentation. The CAP should be submitted by May 16, 2008 to Joseph Millstone at Joseph.Millstone@cms.hhs.gov.	Closed

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Fox Rx Inc.	1-877-369-9564 Ext. 126	S5557	Part D	Ad-Hoc Compliance Event	4/1/2008	Open	Chapter 99: Ad Hoc Compliance Event		As of April 1, 2008 the records of the Centers for Medicare and Medicaid Services (CMS) indicate that Fox Insurance Co., which operates Medicare prescription drug plan (PDP) sponsor contract S5557, does not hold a license as a risk bearing entity in the following state(s): Iowa Maine Minnesota Montana Nebraska New Hampshire North Dakota Oregon South Dakota Washington Wyoming In 2005, CMS issued your organization a three-year waiver (effective January 1, 2006) of the state licensure requirements for the identified state(s) in response to your application and pursuant to CMS¿ authority at 42 C.F.R. §423.410. The licensure waivers expire on December 31, 2008. Once the licensure waivers expire, unless it is licensed as a risk bearing entity in that state, your organization will no longer qualify to operate as a PDP sponsor in the states for which CMS granted the waivers. (42 C.F.R. §423.401(a)) As a result, CMS would non-renew your organization¿s contract (or reduce the contract¿s service area if your organization still has sufficient licenses or unexpired waivers to operate in at least one PDP region) pursuant to 42 C.F.R. §423.507(b)(i) and §423.509(a)(3). CMS must issue its PDP sponsor contract non-renewal notices on or before August 1, 2008 for an effective date of December 31, 2008. (42 C.F.R. §423.507(b)(2)(i)) Therefore, if your organization does not submit to CMS on or before July 31, 2008 documentation that it has obtained the required licenses, contract S5557 will be non-renewed for the 2009 contract year for any PDP regions that include states for which licensure documentation has not been received. Pursuant to 42 CFR §423.507(b)(3), this letter serves as notification that your organization may submit a corrective action plan (CAP) outlining how it will meet the state licensure requirement for the 2009 plan year by July 31, 2008. Please note that your organization should not view the CAP submission as an opportunity to seek CMS approval of an extension of the July 31, 2008 deadline for submitting licensure documentation.	Open

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Longs Drug Stores Corporation	1-801-961-6018	S5644	Part D	Ad-Hoc Compliance Event	4/1/2008	Closed	Chapter 99: Ad Hoc Compliance Event		As of April 1, 2008 the records of the Centers for Medicare and Medicaid Services (CMS) indicate that RxAmerica, LLC, which operates Medicare prescription drug plan (PDP) sponsor contract S5644, does not hold a license as a risk bearing entity in the following state(s): Alabama Arizona California Connecticut Delaware District of Columbia Georgia Hawaii Idaho Iowa Maine Maryland Massachusetts Michigan Minnesota Montana Nebraska Nevada New Hampshire New Jersey New York North Carolina North Dakota Oregon Pennsylvania Rhode Island South Carolina South Dakota Tennessee Texas Utah Vermont Virginia Washington West Virginia Wyoming In 2005, CMS issued your organization a three-year waiver (effective January 1, 2006) of the state licensure requirements for the identified state(s) in response to your application and pursuant to CMS¿ authority at 42 C.F.R. §423.410. The licensure waivers expire on December 31, 2008. Once the licensure waivers expire, unless it is licensed as a risk bearing entity in that state, your organization will no longer qualify to operate as a PDP sponsor in the states for which CMS granted the waivers. (42 C.F.R. §423.401(a)) As a result, CMS would non-renew your organization¿s contract (or reduce the contract¿s service area if your organization still has sufficient licenses or unexpired waivers to operate in at least one PDP region) pursuant to 42 C.F.R. §423.507(b)(i) and §423.509(a)(3). CMS must issue its PDP sponsor contract non-renewal notices on or before August 1, 2008 for an effective date of December 31, 2008. (42 C.F.R. §423.507(b)(2)(i)) Therefore, if your organization does not submit to CMS on or before July 31, 2008 documentation that it has obtained the required licenses, contract S5644 will be non-renewed for the 2009 contract year for any PDP regions that include states for which licensure documentation has not been received. Pursuant to 42 CFR §423.507(b)(3), this letter serves as notification that your organization may submit a corrective action plan (CAP) outlining how it will meet the state licensure requirement for the 2009 plan year by July 31, 2008. Please note that your organization should not view the CAP submission as an opportunity to seek CMS approval of an extension of the July 31, 2008 deadline for submitting licensure documentation. The CAP should be submitted by May 16, 2008 to Joseph Millstone at Joseph.Millstone@cms.hhs.gov.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	4/1/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	APIPA must describe the actions it is taking to ensure that it credentials/recredentials contracted providers in accordance with CMS requirements, on a timely basis. Corrective action must include internal health plan audits of credentialing files to ensure compliance.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	4/1/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	APIPA must describe the actions it is taking to ensure that it is meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Ad-Hoc Compliance Event	4/1/2008	Closed	Chapter 99: Ad Hoc Compliance Event		As of April 1, 2008 the records of the Centers for Medicare and Medicaid Services (CMS) indicate that WellCare Prescription Ins. Co., which operates Medicare prescription drug plan (PDP) sponsor contract S5967, does not hold a license as a risk bearing entity in the following state(s): Alabama Arkansas California Colorado Connecticut Minnesota Mississippi Montana New Hampshire North Carolina Rhode Island Wyoming In 2005, CMS issued your organization a three-year waiver (effective January 1, 2006) of the state licensure requirements for the identified state(s) in response to your application and pursuant to CMS¿ authority at 42 C.F.R. §423.410. The licensure waivers expire on December 31, 2008. Once the licensure waivers expire, unless it is licensed as a risk bearing entity in that state, your organization will no longer qualify to operate as a PDP sponsor in the states for which CMS granted the waivers. (42 C.F.R. §423.401(a)) As a result, CMS would non-renew your organization¿s contract (or reduce the contract¿s service area if your organization still has sufficient licenses or unexpired waivers to operate in at least one PDP region) pursuant to 42 C.F.R. §423.507(b)(i) and §423.509(a)(3). CMS must issue its PDP sponsor contract non-renewal notices on or before August 1, 2008 for an effective date of December 31, 2008. (42 C.F.R. §423.507(b)(2)(i)) Therefore, if your organization does not submit to CMS on or before July 31, 2008 documentation that it has obtained the required licenses, contract S5967 will be non-renewed for the 2009 contract year for any PDP regions that include states for which licensure documentation has not been received. Pursuant to 42 CFR §423.507(b)(3), this letter serves as notification that your organization may submit a corrective action plan (CAP) outlining how it will meet the state licensure requirement for the 2009 plan year by July 31, 2008. Please note that your organization should not view the CAP submission as an opportunity to seek CMS approval of an extension of the July 31, 2008 deadline for submitting licensure documentation. The CAP should be submitted by May 16, 2008 to Joseph Millstone at Joseph.Millstone@cms.hhs.gov.	Closed

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Wellpoint, Inc.	1-303-831-2514	S5596	Part D	Ad-Hoc Compliance Event	4/1/2008	Closed	Chapter 99: Ad Hoc Compliance Event		As of April 1, 2008 the records of the Centers for Medicare and Medicaid Services (CMS) indicate that Anthem Insurance Companies Inc., which operates Medicare prescription drug plan (PDP) sponsor contract S5596, does not hold a license as a risk bearing entity in the following state(s): California New Hampshire In 2005, CMS issued your organization a three-year waiver (effective January 1, 2006) of the state licensure requirements for the identified state(s) in response to your application and pursuant to CMS¿ authority at 42 C.F.R. §423.410. The licensure waivers expire on December 31, 2008. Once the licensure waivers expire, unless it is licensed as a risk bearing entity in that state, your organization will no longer qualify to operate as a PDP sponsor in the states for which CMS granted the waivers. (42 C.F.R. §423.401(a)) As a result, CMS would non-renew your organization¿s contract (or reduce the contract¿s service area if your organization still has sufficient licenses or unexpired waivers to operate in at least one PDP region) pursuant to 42 C.F.R. §423.507(b)(i) and §423.509(a)(3). CMS must issue its PDP sponsor contract non-renewal notices on or before August 1, 2008 for an effective date of December 31, 2008. (42 C.F.R. §423.507(b)(2)(i)) Therefore, if your organization does not submit to CMS on or before July 31, 2008 documentation that it has obtained the required licenses, contract S5596 will be non-renewed for the 2009 contract year for any PDP regions that include states for which licensure documentation has not been received. Pursuant to 42 CFR §423.507(b)(3), this letter serves as notification that your organization may submit a corrective action plan (CAP) outlining how it will meet the state licensure requirement for the 2009 plan year by July 31, 2008. Please note that your organization should not view the CAP submission as an opportunity to seek CMS approval of an extension of the July 31, 2008 deadline for submitting licensure documentation. The CAP should be submitted by May 16, 2008 to Joseph Millstone at Joseph.Millstone@cms.hhs.gov.	Closed
Bethco Corporation	1-718-944-4695	H3329	MA	Audit Findings	3/28/2008	Closed	Section 1 - Clinical PACE Elements		The PACE organization is to provide ongoing training and competencies related to infection control and aseptic technique with a focus on dressing changes. The organization is to develop an infection control review and in-service training for the Nursing Staff. Indicate the time frame for completion, submit training program and include attendance records for related in-services.	Closed
Bethco Corporation	1-718-944-4695	H3329	MA	Audit Findings	3/28/2008	Closed	Section 1 - Clinical PACE Elements		1.CCM must submit a corrective action plan that addresses: a) how it will utilize or amend its current procedures for communicating to the board with respect to PACE reporting, b) allocate time at board meetings to focus on the PACE organizations activities 3) ensure that the governing board has reviewed and approved 2007 evaluation and reviewed and revised or approved the 2008 QAPI plan. 2.The Plan must submit signed copies of Board minutes for two meetings which reflect discussion of ongoing PACE activities and review and approval of QAPI plan.	Closed

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Bethco Corporation	1-718-944-4695	H3329	MA	Audit Findings	3/28/2008	Closed	Section 1 - Clinical PACE Elements		460.106 (a) (b) (1) The PACE organization needs to indicate how they will assure that participant care plans include all pertinent current information, identified problems, recommended interventions and goals. For those participant¿s receiving thickened fluids, the PACE organization is to review existing care plans to assure the consistency of fluids is specified on the physician¿s orders and documented in the care plan. The PACE organization will update the Plan of Care when new needs are identified by the IDT team and will not wait for the bi-annual formal evaluation. The PACE Organization will develop an in-service training on the required documentation for Plans of Care. Indicate the time frame for completion, submit training program and include attendance records for related in-services. The PACE organization needs to develop a methodology to assure Plans of Care contain all required information. 460.104 (f) The PACE organization will develop a policy on transmittal of information to the SNF specific to the POC and Advance Directives. The PACE organization will maintain a copy of the most recent plan of care in the PACE participants skilled nursing facility medical record.	Closed
Bethco Corporation	1-718-944-4695	H3329	MA	Audit Findings	3/28/2008	Closed	Section 1 - Clinical PACE Elements		The PACE organization will provide the nursing home with a copy of the participant¿s advance directive. The PACE organization will develop a plan to ensure that in the future, advance directives information is forwarded to the skilled nursing facility and is retained in the participant¿s medical record. The PACE organization will conduct an audit of PACE skilled nursing participants¿ medical records to ensure that advance directives is maintained in the skilled nursing facility medical record. Provide a timeline for accomplishment and results of audit.	Closed
Bethco Corporation	1-718-944-4695	H3329	MA	Audit Findings	3/28/2008	Closed	Section 3 - Ad Hoc Compliance Events		1. CCM must submit a corrective action plan that addresses a)how it will utilize or amend its current procedures for communicating to the board with respect to PACE reporting, b) how it will allocate time at board meetings to focus on the PACE organization i.e. member satisfaction, complaints and appeals, QAPI program, QA initiatives, c) how the PACE organization will implement the consumer advisory committee member to appropriately update the board. CCM must demonstrate Board Level accountability. 2. Submit signed copies of board minutes for two meetings with PACE information noted, consumer representation and QAPI review and approval, and review of ongoing QA activities.	Closed
Bethco Corporation	1-718-944-4695	H3329	MA	Audit Findings	3/28/2008	Closed	Section 3 - Ad Hoc Compliance Events		1. All employees, contracted staff and delegated vendor staff with direct participant contact must have criminal background checks completed during the hiring process and results to be filed in a separate file from the employee record. 2. The Human Resource department needs to develop a detailed checklist to document the steps that need to be completed during CCM's initial employment process. Develop a policy and process to review new employee records for completeness against the checklist. The internal review should be part of the ongoing quality measures for the Human Resources department. 3. Oversight of delegated vendors requires development of an audit tool that encompasses the required background checks. 4. Submit copy of policy and procedures regarding background checks and develop an audit process for employee files. Submit policy and procedures and checklist to the CMS Regional Office and the NYSDOH. Develop an audit process and audit tool for vendors and submit policy and procedures and audit tool for oversight of delegated vendors to the CMS Regional Office and NYSDOH.	Closed

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	University Health Care must revise its policies and procedures regarding notifying authorized prescribers, network pharmacies, and pharmacists of negative formulary changes (PH 8.01 Communication of Pharmacy Procedure and Changes to Providers) to include the following provisions: - to notify authorized prescribers of negative formulary changes at least 60 days prior to the date the change becomes effective, and - a provision to provide retrospective notice of formulary change to authorized prescribers if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	University Health Care must provide CMS with a CMS approved or accepted notice for notifying enrollees of an adverse standard redetermination consistent with the CMS issued model notice, Notice of Redetermination. If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse standard redetermination concerning drug benefit decision, University Health Care should utilize a CMS accepted or approved Redetermination Notice, that displays the H contract number in the lower left hand corner, and CMS approval date if it was filed under the normal marketing review submission process, in accordance with CMS Marketing guidelines, and provide documentation demonstrating this to CMS.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	University Health Care must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing (PA 80.11: Outreach Representatives Compensation and Commission, MR05: PA 80.18, Enrollment and Understanding of Plan Rules, PA 80.19: Passport Advantage Marketing and Enrollment Training, Passport Health Plan Medicare Outreach Representative Job Description) to include a requirement that any person directly employed or contracted to market on behalf of University Health Care provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. University Health Care must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with documentation that its marketing program monitoring activities confirm that University Health Care has a designated individual responsible for overseeing the activities of the marketing representatives directly employed by University Health Care, as well as documentation demonstrating that these employees are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. University Health Care must also provide CMS with evidence that it has a current signed contract/compensation structure in effect for persons conducting marketing for its Part D plans that includes the following: - a compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans, - a provision for prohibiting payment by the individual/agency performing marketing to beneficiaries, - a provision requiring any person directly employed or contracted to market on behalf of University Health Care provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with University Health Care. The person may be compensated based on your enrollment in a plan.', and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and all Federal health care laws (including civil monetary penalty laws).	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	University Health Care must provide CMS with an analysis and explanation of why the universe submitted for WS-CN2_D contains misclassified cases. Based on the analysis, University Health Care is to provide to CMS, the root cause as well as a detailed corrective action plan.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	University Health Care must revise it policy and procedure regarding enrollee notification of coverage determinations concerning benefit (151D.5 Coverage Determinations for Prescription Medications) to include a provision that states University Health Care must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotations must be included. University Health Care must conduct training of its staff on its policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with a CMS approved or accepted notice for enrollee notification when a request is forwarded to the IRE. (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If University Health Care fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, University Health Care must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. Additionally, University Health Care must submit a new sample upon request from CMS to verify compliance with this requirement.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	University Health Care must provide CMS with a CMS approved or accepted notice for enrollee notification when a request is forwarded to the IRE. (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	University Health Care must revise it policy and procedure regarding decisions to accept or deny requests for expedited coverage determinations (151D.5 Coverage Determinations for Prescription Medications) to include a provision stating that all oral requests must be documented in writing and that documentation of request must be maintained in case file. University Health Care must conduct training of its staff on its policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	University Health Care must revise it policy and procedure 151D.5 Coverage Determinations for Prescription Medications regarding enrollee notification following decision on expedited coverage determination to include a provision that states University Health Care must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. University Health Care must revise its policy 151D.52 Coverage Determinations for Prescription Medications to include a provision that University Health Care must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. University Health Care must conduct training of its staff on its policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with a CMS approved or accepted notice for enrollee notification when a request is forwarded to the IRE. (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must provide notification to the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If University Health Care fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, University Health Care must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. Additionally, University Health Care must submit a new sample upon request from CMS to verify compliance with this requirement.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	University Health Care must revise it policy and procedure regarding enrollee notification following decision on expedited coverage determination (151D.5 Coverage Determinations for Prescription Medications) to include a provision stating that if oral notice is provided for an adverse decision, the notice must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. University Health Care must conduct training of its staff on its policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Upon re-request University Health Care submitted to the audit team a notice template for informing enrollees about inquiries involving an excluded drug. The notice was consistent with CMS issued model notice, Notice of Inquiry Regarding an Excluded Drug. The notice was approved as of January 2008, therefore, no corrective action is required. University Health Care must correctly categorize all requests for coverage determinations concerning payment that are specific to Part D and submit documentation demonstrating this to CMS. Additionally, University Health Care must submit a new sample upon request from CMS to verify compliance with this requirement.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	University Health Care must provide CMS with a CMS approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS issued model notice, Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. University Health Care must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	University Health Care must revise its policies and procedures regarding method of grievance response to include provisions stating: -that all grievances submitted in writing must be responded to in writing, and -that grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response. University Health Care must conduct training of appropriate staff on each of these policies and procedures, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with a CMS approved or accepted notice for informing enrollees of grievance disposition (i.e., a notice consistent with the CMS issued model notice, Notice of Plan's Decision Regarding a Grievance). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Plan's Regarding a Grievance), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. University Health Care must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	University Health Care must revise its policy and procedure regarding grievances related to quality of care to include a provision that states University Health Care's commitment to cooperating with the QIO in resolving grievance cases. University Health Care must conduct training of appropriate staff on each of these policies and procedures, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with a CMS approved or accepted notice for informing enrollees of grievance disposition (i.e., a notice consistent with the CMS issued model notice, Notice of Plan's Decision Regarding a Grievance). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Plan's Regarding a Grievance), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. University Health Care must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	University Health Care must revise its policies and procedures for accepting requests for standard redeterminations (Desk Procedure: Handling Appeals, AP 003: Reconsideration Determinations, AP 007: Effectuating Reconsidered Determinations or Decisions, Policy 151D.5: Coverage Determinations for Prescription Medications) to include provisions for: - accepting written requests for standard redetermination of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination, and - providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. University Health Care must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	University Health Care must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (Desk Procedure: Handling Appeals, AP 003: Reconsideration Determinations, AP 007: Effectuating Reconsidered Determinations or Decisions, Policy 151D.5: Coverage Determinations for Prescription Medications) to include a provision stating that the decision to accept or deny an expedited redetermination request is based on the enrollee's request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health or ability to regain maximum function. University Health Care submitted to the audit team a policy and procedure entitled AP003: Reconsideration Determinations, dated post audit period (2/14/2008) that includes the required provisions stating that: - University Health Care automatically expedites a request when the enrollee's physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health or ability to regain maximum function and, - any additional medical information University Health Care requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. Therefore, no corrective action is required for these provisions. University Health Care must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains a misclassified case. Based on the analysis, University Health Care is to provide to CMS, the root cause as well as a detailed corrective action plan.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	University Health Care submitted to the audit team a policy and procedure entitled AP003: Reconsideration Determinations, dated post-audit period (2/14/2008) that includes the required provisions stating that: - University Health Care must transfer denied request for an expedited redetermination to the standard redetermination timeframe, and - University Health Care must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Therefore, no corrective action is required for these provisions. University Health Care must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Upon re-request University Health Care submitted to the audit team a notice template for notifying enrollees that a request for an expedited redetermination is denied, and found the notice was consistent with CMS issued model notice, Notice of a Right to an Expedited Grievance. The notice was approved as of January 2008. Therefore, no corrective action is required. University Health Care must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains a misclassified case. Based on the analysis, University Health Care is to provide to CMS, the root cause as well as a detailed corrective action plan.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	University Health Care must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning a covered drug benefit (Desk Procedure: Handling Appeals, AP 003: Reconsideration Determinations, AP 007: Effectuating Reconsidered Determinations or Decisions, Policy 151D.5: Coverage Determinations for Prescription Medications) to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring University Health Care to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - University Health Care must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. University Health Care must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with a CMS approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS issued model notice, Request for Reconsideration). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Request for Reconsideration), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must provide CMS with a CMS approved or accepted notice for enrollee notification when a request is forwarded to the IRE. (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must provide notification to the enrollee, or the appointed representative, as applicable, of its standard redetermination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If University Health Care fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, University Health Care must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. If the issue is a denial, University Health Care must provide the enrollee with a CMS approved Request for Reconsideration notice. Additionally, University Health Care must submit a new sample upon request from CMS to verify compliance with this requirement.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	University Health Care must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Desk Procedure: Handling Appeals, AP 003: Reconsideration Determinations, AP 007: Effectuating Reconsidered Determinations or Decisions, Policy 151D.5: Coverage Determinations for Prescription Medications) to include provisions stating: - failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring University Health Care to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - University Health Care must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. University Health Care must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with a CMS approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS issued model notice, Request for Reconsideration). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Request for Reconsideration), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must provide CMS with a CMS approved or accepted notice for enrollee notification when a request is forwarded to the IRE. (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contains a misclassified case. Based on this analysis, University Health Care must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	University Health Care must revise its policies and procedures regarding enrollee notification following a decision on expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (Desk Procedure: Handling Appeals, AP 003: Reconsideration Determinations, AP 007: Effectuating Reconsidered Determinations or Decisions, Policy 151D.5: Coverage Determinations for Prescription Medications) to include: -a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring University Health Care to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -a provision stating that University Health Care must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. University Health Care submitted to the audit team a policy and procedure entitled AP003: Reconsideration Determinations, dated post audit period (2/14/2008) that includes a provision stating that medical information must be requested within 24 hours of the enrollee's initial request. Therefore, no corrective action is required for this provision. University Health Care must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with a CMS approved or accepted notice for enrollee notification when a request is forwarded to the IRE. (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must provide CMS with a CMS approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS issued model notice, Request for Reconsideration). If University Health Care does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS issued model notice, Request for Reconsideration), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. University Health Care must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains a misclassified case. Based on the analysis, University Health Care is to provide to CMS, the root cause as well as a detailed corrective action plan.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	University Health Care must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains a misclassified case. Based on the analysis, University Health Care is to provide to CMS, the root cause as well as a detailed corrective action plan.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	University Health Care must revise its policy and procedure regarding personnel conducting redeterminations to include the following provisions stating: - that a person or persons who were not involved in making the coverage determination conducts the redetermination, and - that if the issue is a denial based on lack of medical necessity, then University Health Care must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. University Health Care must conduct training of appropriate staff on each of these policies and procedures, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with an analysis and explanation of why the universes submitted for WS-RE2_D, Requests for Standard Redeterminations concerning Payment and WS-RE3_D, Requests for Expedited Redeterminations contain misclassified cases. Based on the analysis, University Health Care is to provide to CMS, the root causes as well as detailed corrective action plans.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	University Health Care must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (Desk Procedure: Handling Appeals, AP 003: Reconsideration Determinations, AP 007: Effectuating Reconsidered Determinations or Decisions, Policy 151D.5: Coverage Determinations for Prescription Medications) to state that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at is designated fax number. University Health Care must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with an analysis and explanation of why the universes submitted for WS-RE2_D, Requests for Standard Redeterminations concerning Payment and WS-RE3_D, Requests for Expedited Redeterminations contain misclassified cases. Based on the analysis, University Health Care is to provide to CMS, the root causes as well as detailed corrective action plans.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	University Health Care must demonstrate to CMS that it effectuates third party reversals for a standard appeal of a request for a benefit cases within the timeframes required by CMS and it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses University Health Care's decision.	Open

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University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	University Health Care must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contains a misclassified case. Based on the analysis, University Health Care is to provide to CMS, the root cause as well as a detailed corrective action plan.	Open
University Health Care, Inc.	1-502-585-7925	H1807	MA-PD	Audit Findings	3/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	University Health Care must conduct training of appropriate staff on these policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. University Health Care must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains a misclassified case. Based on the analysis, University Health Care is to provide to CMS, the root cause as well as a detailed corrective action plan.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Chapter 03 - Marketing	Disclosure of Required Information to Beneficiaries - The HCPP provides prospective enrollees adequate written descriptions of its rules, procedures, benefits, fees and other charges, services, Evidence of Coverage (EOC), and other necessary information for the beneficiary at the time of enrollment.	At a minimum, NHN must develop and submit through HPMS for CMS approval an acceptable EOC or EOC equivalent and an acceptable Summary of Benefits (SB) or SB equivalent. Through HPMS, it must also submit for CMS approval an acceptable enrollment form and an acceptable ID card. Any other marketing/sales materials should be submitted for approval after these minimums have been approved.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (CLAIMS PROCESSING)	Medicare Secondary Payer (Claims) - The HCPP has procedures to identify payers which are primary to Medicare, determine the amounts payable, and coordinate benefits. (CMS may not reimburse an organization for services to the extent that Medicare is not the primary payer.)	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Standard Pre-Service Denials (Timeliness) - If the HCPP makes an adverse standard pre-service organization determination, it must notify the member in writing explaining its decision as expeditiously as the member's health condition requires, but no later than 60 days after receiving the request.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Standard Pre-Service Denials (Notice Content) - If the HCPP makes an adverse standard pre-service organization determination explaining the HCPP's decision, it msut notify the member in writing and must clearly state the service denied and denial reason and inform the enrollee of his or her right to a reconsideration, including the right and conditions for obtaining an expedited reconsidered determination.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Receipt and Documentation of Expedited Organization Determination Requests The HCPP must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Requests for Expedited Organization Determinations (Timeliness) - The HCPP must promptly decide whether to expedite an organization determination based on regulatory requirements. If the HCPP decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 2 working days of the oral notice. If the HCPP makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 10 working days if an extension is justified). If the HCPP first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 2 working days of the oral notification.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Expedited Denials (Notice Content) - If the HCPP makes an adverse expedited organization determination a denial notice must be sent to the member. The written denial notice must clearly state the service denied and the denial reason and inform the enrollee of his or her right to a reconsideration, including the right and conditions for obtaining an expedited reconsidered determination.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Decision Not to Expedite an Organization Determination (Notice Content) - If the HCPP decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the HCPP will process the request using the 60 day standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the HCPP grievance process and its timeframes.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open

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National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The HCPP must correctly distinguish between organization determinations and reconsiderations.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	OPTIONAL: Standard Pre-Service Approvals (Timeliness) - If the HCPP makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 60 days after receiving the request.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Claims)	Favorable Claims Reconsiderations (Timeliness) - If the HCPP makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Claims)	Adverse Claims Reconsiderations (Timeliness) - If the HCPP affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The HCPP concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Claims)	Effectuation of Third Party Claims Reconsideration Reversals - If the HCPP's determination is reversed in whole or in part by the independent review entity, the HCPP must pay for the service no later than 60 calendar days from the date it receives the notice reversing the organization determination. The HCPP must also inform the independent review entity that the organization has effectuated the decision. If the determination of the HCPP is reversed in whole or in part by an ALJ, or at a higher level of appeal, the HCPP must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - General)	Acceptance of Standard Reconsideration Requests - The HCPP must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - General)	Appropriate Person(s) Conduct the Reconsideration - A person or persons who were not involved in making the organization determination must conduct the reconsideration.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre-Service)	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the HCPP makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 60 calendar days after receiving the reconsideration request.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre-Service)	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the HCPP is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but no later than 60 calendar days after receiving the reconsideration request. The HCPP must concurrently notify the member of this action.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre-Service)	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the HCPP's determination is reversed in whole or in part by the independent review entity, the HCPP must authorize or provide for the service within 60 days from the date it receives the notice reversing the determination.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre-Service)	Receipt and Documentation of Expedited Reconsideration Requests - The HCPP must maintain procedures for expediting reconsiderations when, upon request from an enrollee or an authorized representative of the enrollee, the organization decides that the longer time frames permitted could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The procedures must include a process for receipt of oral requests, followed by written documentation of the oral requests.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open

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National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre-Service)	Requests for Expedited Reconsiderations (Timeliness) - The HCPP must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the HCPP decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 2 calendar days of the oral notice. If the HCPP decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 10 calendar days if an extension is justified). If the HCPP makes an expedited reconsideration determination that is fully favorable to the member, it must notify the member of the favorable decision as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 10 calendar days if an extension is justified). If the HCPP first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 2 calendar days of the oral notification. If the HCPP affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the HCPP fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the HCPP must submit the file to CMS's independent review entity within 24 hours. The HCPP must concurrently notify the member in writing that it has forwarded the case file to CMS's independent review entity.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre-Service)	Decision Not to Expedite a Reconsideration (Notice Content) - If the HCPP decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the HCPP will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, and provide instructions about the HCPP grievance process and its timeframes.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open

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National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre-Service)	Effectuation of Third Party Expedited Reconsideration Reversals - If the HCPP's determination is reversed in whole or in part by the independent review entity, the HCPP must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 60 days after the date it receives notice reversing the determination.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
National Health Plan Network Inc		H3338	MA	Audit Findings	3/25/2008	Open	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre-Service)	Reconsideration Extensions (Notice Content) - If an extension is taken on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	National Health Plan Network must submit a Corrective Action Plan (CAP) specifically addressing how and when it will correct its gaps and problems in organization, staffing, systems and policies and procedures. The CAP should cover who will make the corrections, who will internally monitor and evaluate progress and completion (should not be same as person or unit that makes the correction), and specifically how NHPN will document to CMS that performance is satisfactory for this element.	Open
NY Hotel Trades Council&Hotel Assn of NYC	1-212-586-6400 Ext. 4340	H6334	MA	Audit Findings	3/21/2008	Closed	Chapter 03 - Marketing	Disclosure of Required Information to Beneficiaries - The HCPP provides prospective enrollees adequate written descriptions of its rules, procedures, benefits, fees and other charges, services, Evidence of Coverage (EOC), and other necessary information for the beneficiary at the time of enrollment.	Hotel Trades must develop a single-document EOC-equivalent that makes clear to the Medicare-eligible retiree the new and complete terms of coverage, cost sharing and procedures when the retiree transitions to Medicare coverage under the Hotel Trades HCPP. This should include some minimal explanation of the differences in appeal procedures (depending on whether the service involved was plan-covered or was Medicare FFS) and how the member will know which appeal procedure to use. Hotel Trades should have policy and procedures on how and when it ensures this information is presented to prospective Medicare-eligible retirees and how it is updated for Medicare enrollees. NOTE: Since the exit conference, Hotel Trades has submitted to CMS (rec'd 2/22/08) a new SB-type document with an extra column to show coverage differences before and after retirement/Medicare.	Closed
NY Hotel Trades Council&Hotel Assn of NYC	1-212-586-6400 Ext. 4340	H6334	MA	Audit Findings	3/21/2008	Closed	Cost Chapter 13 - Organization Determinations, Grievances, and Appeals (CLAIMS PROCESSING)	Medicare Secondary Payer (Claims) - The HCPP has procedures to identify payers which are primary to Medicare, determine the amounts payable, and coordinate benefits. (CMS may not reimburse an organization for services to the extent that Medicare is not the primary payer.)	Hotel Trades must develop and implement P and P for identifying and dealing with situations where another party (not Hotel Trades and not Medicare FFS) has the first liability to pay. Hotel Trades should submit a CAP showing when the P and P will be completed and submitted to CMS and showing when and how Hotel Trades will ensure the procedures have been implemented.	Closed
Triple-S Management Corporation	1-787-273-1110 Ext. 5417	H4012	MA	Audit Findings	3/21/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals		If Triple S makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If Triple S first notifies the member of its expedited determination orally, it must mail written confirmation to the member within three calendar days of the oral notification in accordance with 42 CFR 422.570(c)(2) and (d) and 422.572(a)-(c). Triple S must closely monitor this area to ensure that it complies with this element.	Closed
Triple-S Management Corporation	1-787-273-1110 Ext. 5417	H4005	MA	Audit Findings	3/21/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals		Triple S' EOBs or Notice of Denial of Payment must clearly state the service denied and the specific denial reason, must also inform the enrollee of his her right to a standard reconsideration and describe the appeal process. the revised EOBs were provided to CMS staff while onsite. They were also submitted via HPMS before the conclusion of the visit. Therefore, the only action left is for the MAO to implement and use the revised EOB.	Closed

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Triple-S Management Corporation	1-787-273-1110 Ext. 5417	H4005	MA	Audit Findings	3/21/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals		When Triple S makes a standard pre-service denials the plan should notify the member in writing using the CMS-1003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified). Triple S must closely monitor this area since it was a repeated deficiency and must submit a monthly report to the NY Regional Office indicating the timeliness of the notices.	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	HealthSun must submit the following notices consistent with CMS issued model notices to the Region IV Plan Manager for review and approval: - Request for Additional Information, and - Request for Reconsideration.	Closed

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	HealthSun must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing (MARK 16 Oversight of Marketing Practices, MARK 13 Marketing Controls and Audits, and MARK 3 Sales Representatives Training) to include: - a requirement that all persons marketing on behalf of HealthSun be state licensed, certified or registered individuals, and - a requirement that any person directly employed or contracted to market on behalf of HealthSun provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. HealthSun must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must provide CMS with documentation that its marketing program monitoring activities confirm that HealthSun's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool or sample form used by sales managers or directors in conducting evaluations of sales agents. HealthSun must include provisions within its marketing contract or compensation structure requiring any person employed to perform marketing on behalf of HealthSun provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with HealthSun. The person may be compensated based on your enrollment in a plan'. Additionally, HealthSun must include a provision within its marketing contracts or compensation structures stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal healthcare laws (including civil monetary penalty laws). HealthSun must provide CMS with documentation demonstrating this (i.e., copies of the signed contract or compensation structure containing these required provisions).	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Prior to removing a covered Part D drug from its formulary or making any changes to the preferred tiered cost-sharing status of a covered Part D drug, HealthSun must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide enrollees with a 60 day supply of the Part D drug under the same terms previously allowed. Additionally, HealthSun must use a notice that is compliant with the model notice or CMS requirements (Model Notice 10, Chapter 18 of the Prescription Drug Benefit Manual). HealthSun must submit documentation to CMS demonstrating this.	Open

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	HealthSun must revise its policies and procedures regarding access to long term care pharmacies (Medicare Part D Transition Policy) to include a provision stating that HealthSun must offer standard contracting terms and conditions, including performance and service criteria for long term care pharmacies that CMS specifies, to any long term care pharmacy in its service area that requests the contract. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	HealthSun must revise its policies and procedures for providing notification of formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage (Policy Com PT 002 Response To Immediate Threat To Health and Safety Situations, Policy MED PT 001 Formulary Changes) to include: -a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, -a provision with a description of the procedures for providing a notice of `other' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, -a provision with a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, and -a description of the method(s) used to provide notification of formulary changes. HealthSun must conduct training of appropriate staff on these policies and procedures, including appropriate time frames and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	HealthSun must revise its policy and procedure regarding the transition process for residents of long-term care facilities (Medicare Part D Transition Policy) to include: - requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and -a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSun must conduct training of appropriate staff on each of this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must develop a system report regarding its transition process utilization for LTC residents to demonstrate that: - it correctly implements the transition process for LTC residents as described in its policy and procedure and consistent with its contractual requirements, and - it has and implements a transition process that covers an emergency supply or `first fill' of nonformulary Part D drugs.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	HealthSun must provide CMS with an analysis and explanation of why the universe submitted for WS-CN2_D contained misclassified samples. Based on this analysis, HealthSun must provide to CMS the root cause as well as a detailed corrective action plan.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	HealthSun must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits conducted by HealthSun or its pharmacy benefit manager. HealthSun must conduct training of appropriate staff on the process regarding ongoing monitoring of network pharmacies and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	HealthSun must revise its policy and procedure for receiving, tracking, addressing, and maintaining records of coverage determinations (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) to include provisions: -for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing, -fully defining coverage determination in accordance with § 423.566(b)(1-5), and -for quarterly reporting of all data requested in Reporting Requirements: Appeals HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSun must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If HealthSun fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, HealthSun must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	HealthSun must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) to include provisions stating that: -HealthSun must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -HealthSun must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	HealthSun must revise its policy and procedure regarding enrollee notification following decision on expedited coverage determination (G and A Part D 12 Part D Standard and Expedited Coverage Determinations Process) to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSun must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSun must revise its policy and procedure regarding processing requests for exceptions to its tiered cost-sharing structure (G and A Part D 13 Tiering and Formulary Exception Process) to include provisions stating that: - if HealthSun requires a written statement from the enrollee's prescribing physician, it must request one immediately, and - HealthSun must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must conduct training of appropriate staff to ensure that staff is aware that HealthSun must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSun must revise its policy and procedure regarding processing requests for exceptions for non-formulary drugs (G and A Part D 13 Tiering and Formulary Exception Process) to include a provision stating that HealthSun must grant a formulary exception when it determines that one of the three factors (listed above) has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must conduct training of appropriate staff to ensure that staff is aware that HealthSun must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	HealthSun must revise its policy and procedure regarding determining cost-sharing for approved exceptions (G and A Part D 13 Tiering and Formulary Exception Process) to include a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tiers. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must conduct training of appropriate staff to ensure that staff is aware that enrollees are not required to request an approval of a request for a tiering or nonformulary exception following the initial prescription for the remainder of the plan year and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	HealthSun must revise its policy and procedure regarding the categorization of complaints as inquiries, grievances, or coverage determinations (Policy 009 General Responsibilities for Categorizing Complaints as either a Grievance, Coverage Determination, or Both) to include a provision for promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must provide documentation to CMS demonstrating that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. HealthSun must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures and submit documentation demonstrating this to CMS. HealthSun must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Open

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	HealthSun must revise its policies and procedures regarding tracking, addressing, and maintaining records of grievances (Policy 11 Part D Standard and Expedited Grievance Process) to include a provision for accepting information or evidence concerning the grievance. HealthSun must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must revise its systems for logging and capturing enrollee grievances in a centralized location, to include at a minimum: - the date of receipt of the grievance, - mode of receipt (e.g., fax, telephone, letter, etc.), and - the date HealthSun notified the enrollee of the disposition.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	HealthSun must revise its policy and procedure regarding enrollee notification of grievance disposition (Policy 11 Part D Standard and Expedited Grievance Process) to include a provision stating that all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but not later than 30 days after HealthSun receives the oral or written grievance. HealthSun must conduct training of appropriate staff on this policy and procedure, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must conduct training of appropriate staff to ensure that staff is aware the 30 day timeframe for a grievance may be extended by 14 days or less if the enrollee requests the extension or if HealthSun justifies a need for additional information and documents how the delay is in the interest of the enrollee and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSun must always notify the enrollee of grievance resolutions within the CMS approved timeframes and submit documentation demonstrating this to CMS.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	HealthSun must always notify the enrollee the of grievance resolution and provide documentation demonstrating this to CMS. Specifically, all written grievances must be responded to in writing. If a grievance is submitted orally and the enrollee requests a written response, HealthSun must respond in writing.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	HealthSun must conduct training of appropriate staff to ensure that staff is aware that all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	HealthSun must revise its policy and procedure for accepting and addressing requests for expedited redeterminations (G and A Part D 15, Standard and Expedited Redetermination (Appeals) of an Adverse Coverage Determination) to include: - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. HealthSun must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HealthSun must conduct training of appropriate staff to ensure that staff is aware that any medical information HealthSun requires must be requested within 24 hours of receiving the initial request for an expedited redetermination and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	HealthSun must conduct training of appropriate staff to ensure that staff is aware that HealthSun must transfer denied requests for an expedited redetermination to the standard timeframe and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSun must conduct training of appropriate staff to ensure that staff is aware that any medical information HealthSun requires must be requested within 24 hours of receiving the initial request for expedited redetermination and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	HealthSun must conduct training of appropriate staff to ensure that staff is aware that case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HealthSun must conduct training of appropriate staff to ensure that staff is aware that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HealthSun must conduct training of appropriate staff to ensure that staff is aware that payment must be authorized no later than 72 hours from the date it receives notice reversing the decision and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA-PD	Audit Findings	3/15/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HealthSun must conduct training of appropriate staff to ensure that staff is aware that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	Medica submitted notice templates that had been approved after the audit period. Therefore, no corrective action is required for this element.	Closed
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Medica must revise its policies and procedures (MAR 031 Benefit Advisors Field Observations and MAR 020 Benefit Advisors Employment files) regarding its responsibility for and oversight of persons employed or contracted to perform marketing to include a requirement that any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Medica. The person may be compensated based on your enrollment in a plan'. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Medica must include provisions within its marketing contracts/compensation structure requiring any person employed to perform marketing on behalf of Medica provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Medica. The person may be compensated based on your enrollment in a plan'. Additionally, Medica must include a provision within its marketing contracts/compensation structure stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal healthcare laws (including civil monetary penalty laws).	Closed

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Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Medica must always provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If Medica fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, Medica must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Medica must always provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If Medica fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, Medica must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Medica must always provide notification to the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If Medica fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, Medica must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Medica must revise its policies and procedures (PHR 440 Formulary Exceptions, Exceptions Request: Tracking, Timely Review and Resolution) regarding processing requests for exceptions to its tiered cost-sharing structure to include a provision stating that a Part D sponsor `must grant' a tiering exception when it determinates that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. Specifically, the language in quotation marks must be added. Medica must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Medica must provided CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Medica is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Medica must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, Requests for Standard Redetermination Concerning Drug Benefits, contain misclassified samples. Based on the analysis, Medica is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Medica must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Medica is to provide to CMS, the root cause as well as a detailed corrective action plan.	Closed
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Medica must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Medica is to provide to CMS, the root cause as well as a detailed corrective action plan.	Closed

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Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA-PD	Audit Findings	3/3/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Medica must revise its policies and procedure regarding effectuating third party reversals on an appeal of a request for payment to include a provision stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Palmetto Health Alliance	1-803-434-3770	H4203	MA	Audit Findings	3/3/2008	Closed	Section 1 - Clinical PACE Elements		The PO must submit the following information: 1. Procedure and Policy, Section 61 updates to include: a. Defintion of medication errors as defined by the appropriate professional organization and/or accrediting organization. b. Updates to reflect changes in the reporting of the Pharmacy Review Committee to include medication errors. c. Quality Assurance and Program improvement Committee (QAPI) involvement of tracking and trending medication error rates to include dispensing errors from the pharmacy as well as administration errors from the nursing staff in the center and/or home. 2. Examples of reports and minutes concerning medication errors that will be submitted by the Pharmacy Reveiw Committee to the QAPI Committe for tracking and trending. 3. Training module for the staff that addresses the changes in the Procedure and Policy, Section 61.	Closed
Palmetto Health Alliance	1-803-434-3770	H4203	MA	Audit Findings	3/3/2008	Closed	Section 1 - Clinical PACE Elements		The PACE organization must accomplish the following: 1. Correctly redefine the Y strap belt as a safety belt used only to stabilize bilateral amputees for safe transport between the center and residence. 2. Correctly address the use of the Y-Strap device in their policies as the defined device instead of as a restraint requiring assessment for use beyond a safety belt in the van. 3. Provide CMS with updated policy and procedures to reflect the reason for the use of such a device during transportation. 4. Provide information regarding how assessments of the Y-Strap will be addressed to comply with assessment requirements. 5. Provide CMS with the training material for education of the Interdisciplinary Team (IDT.)	Closed
Palmetto Health Alliance	1-803-434-3770	H4203	MA	Audit Findings	3/3/2008	Closed	Section 2A-Administrative: PACE Elements		The PO must submit the following information : 1. Policy and procedure that addresses proper notification for emergent services. 2. Form letter for notification of notice of non-coverage. 3. Assessment criteria for potential non-compliant participants with ambulance and/or emergency room use. 4. Training module for staff in emergent care notification procedures and assessment criteria.	Closed

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Covenant Health	1-865-670-7214	H4461	MA	Ad-Hoc Compliance Event	2/28/2008	Closed	Chapter 99 - Ad-Hoc Compliance Event		No later than March 10, 2008, Cariten must submit a letter to CMS for approval which will be mailed to all beneficiaries in the identified plan informing them of the copayment error. This letter must clearly state that Cariten incorrectly identified a $150 copayment for Part B drugs. This letter must also inform these beneficiaries that they have a Special Election Period through March 31, 2008 during which time they may make a change in their Medicare Advantage coverage. Cariten must also specifically state in this letter that members must enroll in another Medicare Advantage plan with Part D coverage (MA-PD) or revert to Original Medicare and elect a stand alone Prescription Drug Plan (PDP). This letter must be submitted through the marketing module of HPMS for approval by the Atlanta Regional Office. No later than 2 business days after approval, Cariten must mail this letter to all affected beneficiaries and attest to CMS that the mailing has been completed. Cariten must ensure that printed Summary of Benefits (SB) materials include an errata sheet which includes the appropriate correction in the Part B drug copayment language. Cariten must submit a revised low income subsidy rider and corrections to the EOC for approval in HPMS. Cariten must update its Website to include a copy of the approved letter to the member. Cariten must also notify its contracted providers that an error has been identified, and provide training and educational materials for processing Full Dual Eligible member claims. The MAO must submit a copy of the training materials to the Atlanta Regional Office for our files. Cariten must submit policies and procedures for educating providers on processing claims for Full Dual Eligible plan members as well as a process for monitoring the providers to include the training schedule and sign-in sheet. Cariten is required to attend the upcoming Bid training in CMS¿ Central Office in Baltimore on April 10, 2008 as well as the PBP training in Atlanta on April 24 and 25, 2008. Information on registering for these trainings will be available on HPMS shortly. Cariten H4461-011 must notify beneficiaries disenrolled for loss of eligibility that, upon involuntary disenrollment, CMS will grant the beneficiary a Special Election Period (SEP) in order that s/he may enroll in another MA plan or obtain coverage to supplement Original Medicare. Cariten must also specifically state in this letter that members must retain the Part D drug coverage they presently have, either by enrolling in another Medicare Advantage plan with Part D coverage (MA-PD) or revert to Original Medicare and elect a stand alone Prescription Drug Plan (PDP). This letter must be filed in the marketing module of HPMS for approval by the Atlanta Regional Office. Cariten must verify eligibility via the state Medicaid agency on all beneficiaries disenrolled for loss of eligibility. Cariten must develop a tracking tool to monitor the status of all beneficiaries disenrolled for loss of eligibility to determine if they were disenrolled correctly, identify any coverage gaps, and ensure all claims are processed according to Medicare Guidelines. Cariten must pull all open and closed Complaint Tracking Module cases in HPMS related to H4461 PBP 011 to verify that each beneficiary has been contacted and their issue or concerns have been resolved. Dire need cases should be processed as priority. Cariten must submit their policies and procedures for Transaction Reply Report review to the Atlanta Regional Office. Cariten must respond to this corrective action request with a formal corrective action plan in HPMS as requested by March 10, 2008.	Closed

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Independence Blue Cross	1-215-241-3648	S4496	Part D	Audit Findings	2/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: PBM - The Part D sponsor¿s written contracts with PBMs must comply with all CMS requirements.	In the contract between FutureScripts Secure and Argus, the CMS required provision that states "if the subcontractor will establish the pharmacy network or select pharmacies to be included in teh network, the contract must contain language that the Part D sponsor retains the right to approve, suspend or terminate any arrangement with a pharmacy" is written in a way that FutureScripts Secure or CMS may make this determination instead of the Part D sponsor (reference Appendix 1 to Exhibit J section 6). In addition, the contract submitted was not signed by authorized representatives from either party to the agreement.	Open
Independence Blue Cross	1-215-241-3648	S2321	Part D	Audit Findings	2/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: PBM - The Part D sponsor¿s written contracts with PBMs must comply with all CMS requirements.	In the contract between FutureScripts Secure and Argus, the CMS required provision that states "if the subcontractor will establish the pharmacy network or select pharmacies to be included in teh network, the contract must contain language that the Part D sponsor retains the right to approve, suspend or terminate any arrangement with a pharmacy" is written in a way that FutureScripts Secure or CMS may make this determination instead of the Part D sponsor (reference Appendix 1 to Exhibit J section 6). In addition, the contract submitted was not signed by authorized representatives from either party to the agreement.	Open
Scott and White	1-254-298-3435	H4564	MA	Ad-Hoc Compliance Event	2/14/2008	Closed	Chapter 02 - Enrollment and Disenrollment		The cost plan must submit a revised Corrective Action Plan to address both the origin of this deficiency as well as the specific actions that will be taken to address the identified deficiency. The CAP should include details of how the corrective actions of the plan are consistent with CMS manual instructions for this activity and must also include a provision for internal monitoring and monthly reporting of the results of the corrective actions.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA-PD	Audit Findings	2/12/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Horizon must supply CMS with a CAP (Corrective Action Plan) that satisfies the requirements outlined in the CMS Prescription Drug Benefit Manual, 30.3.4 Provision of Notice Regarding Formulary Changes. The CAP must include provisions for the following: 1. Provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or 2. At the time an affected enrollee requests a refill of the Part D drug, provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed and written notice of the formulary change. The written notice must contain the following information: 3. The name of the affected covered Part D drug 4. Whether the plan is removing the covered Part D drug or changing it¿s preferred or tiered cost-sharing status 5. The reason why the plan is removing such covered Part D drug from the Formulary or changing its preferred or tiered cost-sharing status 6. Alternative drugs in the same therapeutic category or class or cost-sharing tier and expected cost-sharing for those drugs and 7. The means by which enrollees may obtain a coverage determination or exception.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA-PD	Audit Findings	2/12/2008	Closed	Chapter 04: Privacy and Confidentiality	Use of SSN/HICN - The Part D sponsor must use a number other than an enrollee¿s Social Security Number (SSN) or Healthcare Insurance Claim Number (HICN) on enrollee identification cards.	Horizon must supply CMS with a CAP (Corrective Action Plan) that satisfies the requirements outlined in the CMS Prescription Drug Benefit Manual, Chapter 5, 80 Privacy, Confidentiality and Accuracy of Enrollee Records. The CAP must include provisions for the following: 1. Adherence to all Federal and State laws regarding confidentiality and disclosure of Medical records or other health and enrollment information, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Privacy Rule promulgated under HIPAA 2. Ensure that medical information is released only in accordance with applicable Federal and State law 3. Maintain the records and information in an accurate and timely manner and ensure timely access by enrollees to records and information pertaining to them. In addition, Horizon must effectively secure all beneficiary information, whether in paper or electronic format. This includes ensuring that data files are not saved on public or private computers when accessing corporate e-mail through the Internet and ensuring electronic systems are properly programmed for beneficiary mailings to avoid inadvertent disclosures of individually identifiable health information. Horizon should train staff on responsibilities and consequences of failing to secure sensitive beneficiary information. Horizon should also notify CMS immediately upon discovery of any security breach compromising beneficiary personal identifiable information.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA-PD	Audit Findings	2/12/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Horizon must supply CMS with a CAP (Corrective Action Plan) that satisfies the requirements outlined in the Prescription Drug Manual, 20.3 Procedures for Handling a Grievance. The CAP must include provisions for the following: Horizon must supply notification of investigation results to all concerned parties, as expeditiously as the case requires, based on the beneficiary health status, but not later than 30 days after the plan receives the oral or written grievance. All grievances submitted to Horizon in writing must be responded to in writing. Grievances submitted orally may be responded to either orally or in writing, unless the beneficiary requests a written response.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA-PD	Audit Findings	2/12/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Horizon must supply CMS with a CAP (Corrective Action Plan) that satisfies the requirements outlined in the Prescription Drug Manual, 20.3 Procedures for Handling a Grievance. The CAP must include provisions for the following: 1. The ability to accept information or evidence concerning the grievance. 2. Timely transmission of grievances to the appropriate decision making levels when appropriate. 3. Prompt, appropriate action, including a full investigation of the complaint if necessary. In addition, Horizon must disclose grievance data to Medicare beneficiaries upon request. Horizon must also be able to log or capture beneficiary grievances in an accessible, centralized location.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA-PD	Audit Findings	2/12/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Horizon must supply CMS with a CAP (Corrective Action Plan) that satisfies the requirement outlined in the Prescription Drug Manual, 70.7 Time Frames and Responsibilities for Conducting Standard Redeterminations. The CAP must include provision for the following: 1. If Horizon denies a request for an expedited redetermination it must automatically transfer the request to the standard redetermination timeframe and provide prompt oral notice to the beneficiary. Horizon must also provide a written notice within 3 calendar days of the oral notice. 2. Horizon must notify the beneficiary in writing of its redetermination, whether favorable or adverse, as expeditiously as the beneficiaries health condition requires, but no later than 7 calendar days from the date that Horizon receives the request.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA-PD	Audit Findings	2/12/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Horizon must supply CMS with a CAP (Corrective Action Plan) that satisfies the requirement outlined in the Prescription Drug Manual, 70.7 Time Frames and Responsibilities for Conducting Standard Redeterminations. The CAP must include policies and procedures for the following: If Horizon grants a request for an expedited redetermination, it must complete its redetermination and give the beneficiary (and the prescribing provider) notice of its decision as soon as possible but no later than 72 hours after receiving the request. If medical information is necessary Horizon must make the request within 24 hours of the initial request. Failure to do so constitutes an adverse redetermination, which would require Horizon to send the beneficiary request to the IRE within 24 hours.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	S5993	Part D	Audit Findings	2/12/2008	Closed	Chapter 01: Enrollment and Disenrollment	Voluntary Disenrollment Process ¿ Notice to Enrollee - The Part D sponsor must provide the enrollee with a notice of disenrollment that CMS approves within 7 business days of receipt of the disenrollment request from the individual, or within 7 business days of notification via the reply listing.	Plan must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its disenrollment process to assure that member requests are processed according to CMS requirements. Plan should submit a summary report once a quarter to the regional office of its monthly findings until further notice beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	S5993	Part D	Audit Findings	2/12/2008	Closed	Chapter 01: Enrollment and Disenrollment	Notice Acknowledging the Receipt of Completed Enrollment Election - The Part D sponsor must provide a notice acknowledging receipt of the completed enrollment request prior to the effective date of enrollment, or if late in election period within 7 business days of its receipt, unless the Part D sponsor combines the acknowledgement and confirmation notice.	Plan must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its enrollment process to assure that member requests are processed according to CMS requirements. Plan should submit a summary report once a quarter to the regional office of its monthly findings until further notice beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	S5993	Part D	Audit Findings	2/12/2008	Closed	Chapter 01: Enrollment and Disenrollment	Enrollment Notice Requirement (Timeliness) - Once the Part D sponsor receives a reply listing report from CMS indicating whether the individual¿s enrollment has been accepted or rejected, the Part D sponsor must notify the individual of CMS¿ acceptance or rejection of the enrollment within 7 business days of the availability of the of the monthly TRR, or within 5 business days of receipt of the weekly "mini" TRR if the Part D sponsor provided all information and required notices together.	Plan must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its enrollment process to assure that member requests are processed according to CMS requirements. Plan should submit a summary report once a quarter to the regional office of its monthly findings until further notice beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	S5993	Part D	Audit Findings	2/12/2008	Closed	Chapter 01: Enrollment and Disenrollment	Enrollment Notice Requirement (Notice Content) - The Part D sponsor must provide the individual with a notice of CMS¿ acceptance or rejection of the enrollment in a format and manner specified by CMS.		Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	S5993	Part D	Audit Findings	2/12/2008	Closed	Chapter 01: Enrollment and Disenrollment	Confirmation of Enrollment for Members of Employer Group/Union Receiving Employer Subsidy - The Part D sponsor must meet CMS requirements for obtaining a confirmation of the intent to enroll from any individual who attempts to enroll in the Part D plan, but whose enrollment is conditionally rejected by CMS due to a detected match indicating that the beneficiary may have existing Employer or Union drug coverage.	Plan must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its enrollment process to assure that member requests are processed according to CMS requirements. Plan should submit a summary report once a quarter to the regional office of its monthly findings until further notice beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	S5993	Part D	Audit Findings	2/12/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Horizon must conduct training of appropriate staff on the grievance and coverage determination processes and the necessity to maintain appropriated documentation of these processes. Please submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	S5993	Part D	Audit Findings	2/12/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.		Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Compliant Disenrollment Process - The MAO disenrolls Medicare members, when appropriate, upon receipt of a request for disenrollment. The MAO annotates its own system and the CMS system with the correct disenrollment effective date.	Horizon must develop a corrective action plan which should include at a minimum the following: 1. Develop and enhance policies and procedures related to the processing of disenrollments. 2. Implement a internal quality audit process which addresses disenrollment processing. 3. Assure processes are in place so that documentation regarding disenrollment processing is available for all members processed. 4. Assure that all staff involved in disenrollment processing are trained in proper procedures. Provide documentation to the regional office that all training has occurred.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.	Horizon must develop and implement a corrective action plan to resolve deficiencies which includes at a minimum the following elements: 1. Develop and implement a policy and procedure which addresses the issue of mailing out the disenrollment notices timely. 2. Provide training to all staff involved in processing disenrollment notices to assure understanding of process and CMS requirements. 4. Establish an internal quality audit process to assure compliance.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Notice Content) - The MAO sends the disenrollment notice to the member in a format specified by CMS, providing the correct effective date of disenrollment.	Horizon must develop and implement a corrective action plan to resolve deficiencies which includes at a minimum the following elements: 1. Develop and implement a policy and procedure which addresses the issue of sending disenrollment notices to the members in a format specified by CMS and providing the correct effective date of disenrollment 2. Provide training to all staff involved in processing and sending disenrollment notices to members in the correct format with the correct effective dates. 3. Establish an internal quality audit process to assure compliance for this element.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Refund of Premium - The MAO must refund all amounts incorrectly collected from its Medicare members or from others on their behalf.	Horizon must develop and implement a corrective action plan to resolve deficiencies which includes at a minimum the following elements: 1. Develop and implement a policy and procedure which addresses the issue of refunding all amounts incorrectly collected from its Medicare members or from others on their behalf. 2. Provide training to all staff involved in processing premium refunds as per CMS' requirements. 3. Establish an internal quality audit process to assure compliance.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Involuntary Disenrollment for Non-Payment of Premium (Optional) - The MAO may involuntarily disenroll Medicare members who fail to pay monthly basic or supplementary premiums only after demonstrating to CMS that the MAO has made reasonable efforts to collect the unpaid premium amount, including notifying the individual that the premiums are delinquent, providing the individual with a grace period to pay past premiums due, and advising the individual that failure to pay will result in termination. The MAO may only disenroll the Medicare member when the MAO has not received payment within a grace period of a minimum of 1 calendar month that begins on the first day of the month for which the premium was not paid. The effective date of disenrollment is the first day of the month after the period ends.	If Horizon decides to terminate a member due to non-payment of premium must ensure that its policy and procedures reflect this information. In addition Horizon must provide refresher training to all applicable staff to ensure that policy and procedures are followed in accordance with CMS guidelines.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Involuntary Disenrollment for Move Out of Service Area - The MAO must disenroll Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than six (6) months, unless they move into an approved plan continuation area and the member has elected the continuation of enrollment option. Member notice is required prior to transmission of the disenrollment to CMS.	The MAO must develop and implement a corrective action plan to resolve deficiencies which includes at a minimum the following elements: 1. Develop and implement a policy and procedure which addresses the issue of disenrolling Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than six (6) months. 2. Provide training to all staff involved in processing disenrollments to assure compliance of CMS requirements. 3. Establish an internal quality audit process to assure compliance.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Compliant Retroactive Disenrollment Requests - The MAO correctly submits requests to the CMS Regional Office, or Program Safeguard Contractor, for retroactive disenrollments in instances where, due to CMS error, there was never a legally valid enrollment or a valid request for disenrollment was properly made but not processed or acted upon. Supporting information is included in accordance with CMS policy.	Horizon must ensure that all transactions submitted to CMS or its delegates are valid and that the Plan possesses all necessary documentation to support such submissions.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Correct Enrollment Election - Elections must be completed by the beneficiary or representative.	Horizon must develop and implement a corrective action plan to resolve deficiencies which includes at a minimum the following elements: 1. Develop and implement a policy and procedure which addresses the issue of correct enrollment election with operational accountabilities in appropriate functional areas. 2. Provide training to all staff involved in processing enrollment elections to assure understanding of process and CMS requirements. 3. Assure that record keeping procedures are sound so that complete documentation for any member's enrollment record is retrievable. 4. Establish an internal quality audit process to assure compliance. 5. Provide documentation to the Regional Office that systems have been reviewed and improved and that training has occurred.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Receipt - Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.	Horizon must develop corrective action which at a minimum includes the following elements: 1. Review existing policy with relevant staff involved in application processing to assure that all are trained and understand procedures. 2. Develop internal quality audit process to assure prospectively and retrospectively that enrolllment elections received are date stamped with 100% compliance. 3. Develop and implement immediate measures to assure integrity of archived documents and the ability to retrieve them. 4. Provide documentation to the Regional Office that training and corrective actions have been implemented and are ongoing.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Effective Date (Timeliness) - The MAO enrolls Medicare beneficiaries with a correct effective date and type based on the appropriate election period.	Horizon must develop and implement a corrective action plan to resolve deficiencies that prevent a determination that members are enrolled with the correct effective date based on the appropriate election period. This corrective action must include at a minimum the following elements: 1. Develop and/or enhance policies and procedures that address the issue of correct enrollment effective dates with operational accountabilities in appropriate functional areas. 2. Provide training to all staff involved in processing enrollment to assure understanding of process and CMS requirements regarding effective dates and enrollment periods. 3. Assure that record keeping procedures are sound so that complete documentation for any member's enrollment record is retrievable. 4. Establish an internal quality audit process to assure compliance. 5. Provide documentation to the Regional Office that systems have been reviewed and improved and that training has occurred.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.	Horizon must implement corrective action to assure compliance which includes at least the following elements: 1. Review existing polices and procedures to assure specific language targets compliance with this standard and that appropriate accountabilities are in place. If necessary develop and implement new policies and procedures which address the standard more directly. 2. Develop and implement internal quality audit procedures to be performed at least on a quarterly basis to assure compliance with this standard. Any adverse findings should be documented and corrective action implemented. Results of quarterly audits are to be submitted to the Regional Office. 3. Conduct and document training for all staff with accountability for identifying and following up with incomplete enrollment elections. Provide documentation of such training to the Regional Office. 4. Assure that record keeping procedures are sound so that complete documentation for any member's enrollment record is retrievable.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS.	While Horizon has a policy titled Enrollment Application Processing, which specifies that enrollment confirmation letters are sent, in many cases there was no way to confirm this due to a high degree of poor records maintenance. Horizon must develop and implement a corrective action plan to address the deficiencies noted in this finding, in particular: 1. Adopt measures to assure that all documentation of all enrollment records is retained and accessible. 2. Establish and maintain an internal quality assurance mechanism that asseses the degree of compliance with this standard and assures that internal controls are working. 3. Be able to demonstrate that upon identification of instances of non-compliance, corrective action has been taken to bring into compliance.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Notice Content) - The written acknowledgement notice, sent in response to the beneficiary's enrollment election, meets CMS requirements and specifies the correct effective date of enrollment.	Horizon must make every effort to improve the degree of compliance measured by element ER06 and must develop and implement a corrective action plan to resolve deficiencies which includes at a minimum the following elements: 1. Develop and implement a policy and procedure which specifically addresses the issue of enrollment acknowledgment letter content. 2. Provide training to all staff involved in processing enrollment elections to assure understanding of process and CMS requirements. 3. Assure that record keeping procedures are sound so that complete documentation for any member's enrollment record is retrievable. 4. Establish an internal quality audit process to assure compliance. 5. Provide documentation to the Regional Office that systems have been reviewed and improved and that training has occurred.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.	The MAO must develop and implement a corrective action plan to resolve deficiencies which includes at a minimum the following elements: 1. Develop and implement a policy and procedure which addresses the issue of the MAO receiving information from CMS, and promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment. 2. Provide training to all staff involved in receiving the information and notifying members within specific timeframes specified by CMS. 3. Establish an internal quality audit process to assure compliance	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	The MAO must develop and implement a corrective action plan to resolve deficiencies which includes at a minimum the following elements: 1. Develop and implement a policy and procedure which addresses the issue of sending final notice of enrollment to the beneficiary, which describes CMS' acceptance or rejection of enrollment and meets CMS requirements. 2. Provide training to all staff involved in processing enrollment and sending out the notices as per CMS requirements. 3.Establish an internal quality audit process to assure compliance.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Submission of Enrollment Transactions to CMS - The MAO follows CMS guidelines for submitting enrollment transactions to CMS.	Horizon must ensure that all transactions submitted to CMS or its delegates are valid and that the Plan possesses all necessary documentation to support such submissions.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Horizon must develop and implement a policy that specifically addresses member understanding of plan rules. In addition internal quality improvement audits should address compliance with all aspects of this element.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 03 - Marketing	Appropriate Notice Given to Members Before Plan Rule Change - If the MAO intends to change its rules for an MA plan, it must give notice to all members at least 30 days before the intended effective date of the change.	Horizon must develop and implement a policy and procedure that addresses compliance with this element that assures members receive timely notice in the event of plan rule changes above and beyond issuing the ANOC. In addition, internal audit procedures must demonstrate periodic compliance assessment for this element. The title of the person charged with internal audit for this element must be provided.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.	Horizon must resubmit HSD 1, 2 3 and 4 Tables in both hard copy and electronic versions according to the published format and instructions and only after non-Medicare and inappropriate providers are removed. Horizon must also assure that providers listed on HSD 3 are appropriately classified and, in the case of HHAs, listed only in those counties where they are licensed to provide services. Once the HSD tables are corrected, the Provider Directory must be revised to reflect the Medicare Advantage network accurately. Submit a timeline for the correction of the hard copy and online versions. CMS will determine network sufficiency once the corrected HSD tables are received.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 04 - Benefits and Beneficiary Protections	PCP Panel Established and Maintained - The MAO establishes, maintains, and monitors a panel of primary care providers from which the member may select a personal primary care provider.	Horizon needs to put a process in place for assigning a PCP when a member fails to select their PCP. Submit the process to CMS upon completion.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 04 - Benefits and Beneficiary Protections	Member Health Record Uses Established StandardsAll MAOs that offer CCPs must ensure that each provider furnishing services to members maintains member health records in accordance with standards established by the MAO, which take into account professional standards.	Horizon needs to revise their policy and procedure for Medical Record Documentation Standards to include the areas indicated above in order to be compliant with CMS requirements. In addition, the Audit procedures and tools need to include these areas. Horizon needs to advise providers of the revised standards and audit procedures. Furnish CMS with a copy of the revised policies, procedures, audit tool and provider notification.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Horizon Healthcare of New Jersey must submit a plan outlining how they will assure that providers credentialed and recredentialed by delegated entities meet CMS and Horizon requirements. Include a timeline for ensuring that all credentialing and recredentialing files completed by delegated entities are compliant. Corrective action needs to include how Horizon will ensure that all recredentialing is done in a timely manner or that providers are terminated from the network as per policy. Include a timeline for assuring that all network providers are currently recredentialed. Also, indicate how Horizon will assure that all credentialing and recredentialing criteria are met for the current their network. The plan needs to include the Quality initiatives to for assuring continued compliance and the person responsible.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Horizon Healthcare of New Jersey must submit a plan outlining how they will assure that ancillary providers meet Horizon¿s credentialing and recredentialing requirements. Include a timeline for ensuring that all ancillary credentialing and recredentialing files are complete and include only Medicare certified providers. The plan needs to include the Quality initiatives for assuring continued compliance and the person responsible. Revise the Credentialing/Recredentialing Policy for Ancillary Providers to include Clinical Laboratories and Mobile X Ray providers. Submit the revised policy to CMS when completed.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 06 - Provider Relations	Discrimination Against Health Care Professionals ProhibitedAn MAO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.	Corrective Action Required: Horizon Healthcare needs to modify their policy to include the missing language and notify their providers of the change. Submit a copy of the revised policy and a copy of the notification sent to the providers to CMS.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 06 - Provider Relations	No Prohibition on Health Care Professional Advice to PatientsAn MAO may not prohibit a health care professional from advising or advocating on behalf of a patient.	Horizon Healthcare needs to develop a vehicle to advise providers and members that providers are permitted to give information about alternative treatments that may be self administered, including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options, the benefits and consequences of treatment or non-treatment, and allow the opportunity for the member to refuse treatment and to express preferences about future treatment decisions. Horizon needs to include the missing language in the Managed Care Network Office Manual when it is reprinted. Submit a copy of the provider and member notification to CMS and indicate when the Managed Care Network Office Manual will be updated.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Horizon must conduct training of appropriate staff to ensure required grievance notifications are sent to members when appropriate. Horizon must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Horizon must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Horizon must conduct training of appropriate staff to ensure required grievance notifications are sent to members when appropriate. Also these notices must have the required language. Horizon must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Also Horizon must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	Horizon must conduct training of appropriate staff to ensure required grievance notifications are sent to members when appropriate. Horizon must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Also Horizon must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

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Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	In accordance with Medicare Guidelines, Horizon and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Horizon must develop and implement an ongoing internal quality audit process that assures 100% compliance with the requirements of this element in order to demonstrate that 95% of non-par provider clean claims are paid within 30 days of receipt. Horizon must submit quarterly results of these audits to the regional office until two consecutive quarters report 100% compliance. Horizon must ensure that its delegated entity adheres to these requirements.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Horizon must develop and implement an ongoing internal quality audit process that assures 100% compliance with the requirements of this element in order to demonstrate that 100% of non-par provider clean claims paid late include the correct interest payment both internally and with their delegated entities. Horizon must submit quarterly results of these audits to the regional office until two consecutive quarters report 100% compliance.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	In accordance with Medicare Guidelines, Horizon and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	If Horizon or it's designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The Standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Horizon must develop and implement policies and procedures that assure pre service requests are appropriately processed within required timeframes. Horizon must ensure that manual and automated systems are functioning to assure CMS requirements are met. Horizon must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Horizon must develop and implement policies and procedures regarding notification to members. In addition, Horizon must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Horizon must also confirm that its delegated also implements said process.	Closed
Horizon Blue Cross Blue Shield of New Jersey, Inc.	1-973-466-5169	H3154	MA	Audit Findings	2/12/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	Horizon must ensure that if it affirms, in whole or in part, its adverse organization determination (i.e., continues to deny payment in whole or in part), it must prepare a written explanation and send the complete case file to the independent review entity contracted by CMS. This must be completed no later than 60 calendar days from the date it receives the request for reconsideration. Horizon must make reasonable and diligent efforts to gather and forward information to the independent review entity. Horizon must also notify the enrollee that the case has been forwarded to the independent review entity. If CMS determ ines that Horizon has a pattern of not making a reasonable and diligent effort to gather and forward information to the independent review entity, Horizon will be considered in breach of its Medicare contract.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-303-344-7758	H0630	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed

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Kaiser Foundation Health Plan, Inc.	1-404-364-4923	H1170	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-808-432-5230	H1200	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-808-432-5230	H1230	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-301-816-5737	H2150	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6050	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed

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Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6052	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-216-479-5694	H6360	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-503-813-4948	H9003	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-503-813-4948	H9103	MA	Ad-Hoc Compliance Event	2/11/2008	Closed	Chapter 02 - Enrollment and Disenrollment		CMS recognizes that implementing the system changes sooner than July 2008 may interfere with Kaiser¿s testing and implementation other changes. CMS would like Kaiser to attempt to implement these system requirements sooner. Kaiser must describe the actions KP National will take to ensure that there is a work around until system implementation is in place. A description of the actions Kaiser will take to correct this deficiency. A timetable for when each activity will be fully implemented as well as the Kaiser staff member responsible for implementation. A description of the measures Kaiser will employ to ensure continued compliance after the corrective actions are in place.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Ad-Hoc Compliance Event	2/8/2008	Closed	Chapter 02 - Enrollment and Disenrollment		KPCA must describe the actions KPCA will take to ensure that the correct retroactive packets are sent to Integriguard are complete and accurate and that the retractive transactions are worked by KPCA timely within Chapter 2 guidelines.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Ad-Hoc Compliance Event	2/8/2008	Closed	Chapter 02 - Enrollment and Disenrollment		KPCA must describe the actions KPCA will take to ensure that the correct retroactive packets are sent to Integriguard are complete and accurate and that the retroactive transactions are worked by KPCA timely within Chapter 2 guidelines.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Samaritan Advantage must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing (MK-2 Sales Oversight Policy) to include a requirement that all persons marketing on behalf of Samaritan Advantage be state licensed, certified or registered individuals. Samaritan Advantage must conduct ongoing monitoring of the marketing activities of internal and external marketing representatives. Specifically, Samaritan Advantage must demonstrate that it has designated an individual responsible for overseeing the activities of internal and external marketing representatives, such as marketing representatives, agents and brokers and provide documentation demonstrating this to CMS. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must include provisions within its marketing contracts requiring any person employed to perform marketing on behalf of Samaritan Advantage provide a written disclosure statement to all potential enrollees prior to or at the time of enrollment. The written disclosure statement must state the following: 'The person this is discussing plan options with you is either employed by or contracted with Samaritan Advantage. The person may be compensated based on your enrollment in a plan', and provide documentation demonstrating this to CMS.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	Samaritan Advantage must revise its policies and procedures regarding the transition process for residents of long-term care facilities (RX-9, LTC and Part D Medicare Disparities and RX-21, Medicare Transition Period) to include provisions for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and abide by extensions to the transition period in accordance with CMS policy. Samaritan Advantage must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must develop or utilize a system that is capable of tracking its enrollees that are in LTC facilities. This system must track that: -Samaritan Advantage correctly implements the transition process for LTC residents in accordance with CMS requirements, and -Samaritan Advantage has and implements a transition process that covers an emergency supply or 'first-fill' of non-formulary Part D drugs. Samaritan Advantage must submit documentation demonstrating this to CMS.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Samaritan Advantage must accept and process requests for reimbursement for Part D drugs in accordance with standard coverage determination procedures and timeframes and create policies and procedures to reflect this. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide notification to enrollees of both adverse and favorable coverage determination and redetermination decisions and use its systems to track and address this notification in accordance with CMS requirements.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Samaritan Advantage must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (RX-2 Coverage Determinations, Exceptions, and Appeals) to include a provision stating that Samaritan Advantage must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Samaritan Advantage must provide notification to enrollees of both adverse and favorable coverage determination decisions within timeframes consistent with CMS requirements. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is compliant with CMS requirements. Additionally, Samaritan Advantage must forward untimely cases to the IRE in accordance with CMS requirements. Samaritan Advantage must provide documentation demonstrating this to CMS.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Samaritan Advantage must create policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following the provisions: - Samaritan Advantage must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - Samaritan Advantage must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - Samaritan Advantage must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Samaritan Advantage must provide CMS with a CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage that contains the required OMB control number displayed in the upper right-hand corner of the notice. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When Samaritan Advantage makes an adverse standard coverage determination concerning drug benefit decision, it must always notify the enrollee, or the appointed representative, as applicable, of its decision, through the use of a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Samaritan Advantage must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (RX-2 Coverage Determinations, Exceptions, and Appeals) to include a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for notifying an enrollee that a request for an expedited coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Samaritan Advantage must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (RX-2 Coverage Determinations, Exceptions, and Appeals) to include the following provisions stating that Samaritan Advantage: - must make its expedited coverage determination and notify the enrollee (and/or applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or for an exceptions request, the physician's supporting statement, and - must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must always provide notification of expedited coverage determination decisions, both adverse and favorable, to the enrollee, or appointed representative, when applicable, within timeframes consistent with CMS requirements and provide documentation demonstrating this to CMS. Additionally, Samaritan Advantage must forward untimely cases to the IRE in accordance with CMS requirements and provide documentation demonstrating this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Samaritan Advantage must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (RX-2 Coverage Determinations, Exceptions, and Appeals) to include provisions stating that: - if the decision is adverse, then Samaritan Advantage must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and - if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage that contains the required OMB control number displayed in the upper right-hand corner of the notice. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Samaritan Advantage must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (RX-2 Coverage Determinations, Exceptions, and Appeals and Formulary Tier Exception) to include the following provisions stating that: -if Samaritan Advantage requires a written statement from the enrollee's prescribing physician it must do so immediately, -if Samaritan Advantage makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, -Samaritan Advantage must not keep an exceptions request open indefinitely when a physician does not submit a supporting statement, -if Samaritan Advantage is waiting on a physician's statement in support of a tiering exception request, Samaritan Advantage must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception, and -a Part D sponsor must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Samaritan Advantage must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (RX-2 Coverage Determinations, Exceptions, and Appeals) to include the following provisions stating that: - the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - the Part D sponsor must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - if Samaritan Advantage makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, -Samaritan Advantage must not keep an exceptions request open indefinitely when a physician does not submit a supporting statement, and -if Samaritan Advantage is waiting on a physician's statement in support of a formulary exception request, Samaritan Advantage must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Samaritan Advantage must revise its policies and procedures regarding determining cost-sharing for approved exceptions (RX-2 Coverage Determinations, Exceptions, and Appeals and Formulary Tier Exception) to include provisions stating that: - coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, - enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and - all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Samaritan Advantage must revise its policies and procedures regarding the categorization of complaints as inquiries, grievances, or coverage determinations/appeals (Policy RX-7, Grievances, Policy RX-2 Coverage Determinations, Exceptions, and Appeals, and Distinguishing Complaints) to include provisions for promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved notice for informing enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If Samaritan Advantage does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. Samaritan Advantage must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. Samaritan Advantage must submit documentation demonstrating this to CMS.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Samaritan Advantage must revise its grievance policies and procedures regarding tracking, addressing, and maintaining records of grievances (RX-7, Grievances) to include: -a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary, and -a provision for tracking and maintaining, at a minimum, the date of receipt, disposition of the grievance, and the date that the enrollee was notified of the disposition. Samaritan Advantage must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Samaritan Advantage must revise its policies and procedures regarding enrollee notification of grievance disposition (RX-7, Grievances) to include provisions stating that: -all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but not later than 30 days after Samaritan Advantage receives the oral or written grievance, -30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if Samaritan Advantage justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when Samaritan Advantage extends the deadline. Samaritan Advantage must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Samaritan Advantage must revise its policies and procedures regarding method of grievance responses (RX-7 Grievances) to include a provision stating that grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response. Samaritan Advantage must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance resolution using methods that are CMS compliant.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide documentation to CMS that demonstrates it has developed and implemented procedures for responding to quality of care grievances in writing and that it is including a description of the enrollee's right to file a written complaint with the QIO in its written response. Samaritan Advantage must also develop and implement procedures for distinguishing between QOC Grievances and Standard Grievances. Samaritan Advantage must conduct training of appropriate staff on these procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Samaritan Advantage must revise its policies and procedures for accepting requests for standard redeterminations (RX-2 Coverage Determinations, Exceptions, and Appeals) to include provisions for: - accepting written requests for standard redeterminations of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination, and - providing reasonable opportunity to received evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Samaritan Advantage must revise its policies and procedures for accepting and addressing requests for expedited redeterminations (RX-2 Coverage Determinations, Exceptions and Appeals) to include a provision for documenting all oral requests in writing. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Samaritan Advantage must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (RX-2 Coverage Determinations, Exceptions and Appeals) to include a provision stating that any additional medical information Samaritan Advantage requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for notifying an enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Samaritan Advantage must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (RX-2 Coverage Determinations, Exceptions, and Appeals) to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Additionally, Samaritan Advantage must conduct training of appropriate staff on the use of these notice templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, Samaritan Advantage must provide to CMS the root cause as well as a detailed corrective action plan.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Samaritan Advantage must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (RX-2 Coverage Determinations, Exceptions, and Appeals) to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Additionally, Samaritan Advantage must conduct training of appropriate staff on the use of these notice templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D, Requests for Standard Redeterminations Concerning Payment, contained misclassified samples. Based on the analysis, Samaritan Advantage must provide to CMS the root cause as well as a detailed corrective action plan	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Samaritan Advantage must revise its policies and procedures regarding enrollee notification following decision on expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (RX-2 Coverage Determinations, Exceptions, and Appeals) to include the following provisions: - the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its redetermination as expeditiously as the enrollee's health condition requires, but not later than 72 hours after it received the request for an expedited redetermination, - initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, - medical information must be requested within 24 hours of the enrollee's initial request, and - Samaritan Advantage must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Samaritan Advantage must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If Samaritan Advantage does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. Additionally, Samaritan Advantage must conduct training of appropriate staff on the use of these notice templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Samaritan Advantage must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (RX-2 Coverage Determinations, Exceptions, and Appeals) to state that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. Samaritan Advantage must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Samaritan Advantage must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations concerning Drug Benefits, and WS-RE2_D, Requests for Standard Redeterminations concerning Payments, contained misclassified samples. Based on the analysis, Samaritan Advantage must provide to CMS the root cause as well as a detailed corrective action plan	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Samaritan Advantage must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations concerning Drug Benefits, contained misclassified samples. Based on the analysis, Samaritan Advantage must provide to CMS the root cause as well as a detailed corrective action plan.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA-PD	Audit Findings	2/4/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Samaritan Advantage must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D, Requests for Standard Redeterminations concerning Payments, contained misclassified samples. Based on the analysis, Samaritan Advantage must provide to CMS the root cause as well as a detailed corrective action plan.	Closed

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Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	(1) DHMP must submit to CMS its policies and procedures regarding responsibility for and oversight of persons performing marketing activities. This documentation must include a provision to conduct ongoing monitoring of all persons directly employed or contracted to perform marketing activities to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines. (2) DHMP must submit to CMS its policies and procedures that include a requirement that its marketing representatives provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment stating that the person discussing plan options is employed and compensated by DHMP. (3) DHMP must submit to CMS a written policy requiring that all persons marketing on behalf of the Plan be state licensed.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	DHMP must submit to CMS policies and procedures that state standard contracting terms and conditions, including performance standards and service criteria for Long Term Care (LTC) pharmacies that CMS specifies, to any LTC pharmacy in the service area that requests the contract.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	DHMP must submit to CMS a notice template for enrollee notification when request is forwarded to the IRE. This notice needs to be consistent with CMS issued model notice, Notice of Case Status.	Closed

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Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	DHMP must submit to CMS a notice template for enrollee notification when request is forwarded to the IRE. This notice needs to be consistent with CMS issued model notice, Notice of Case Status.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	DHMP must submit to CMS policies and procedures that state the enrollee must be informed within 24 hours, when the case is forwarded to the IRE. DHMP must submit to CMS a notice template for enrollee notification when request is forwarded to the IRE. This notice needs to be consistent with CMS issued model notice, Notice of Case Status.	Closed

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Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Denver Health must submit to CMS Monthly expedited coverage determination case files until sufficient evidence is documented that proper notice is provided to enrollees concerning expedited coverage determinations.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	DHMP must update its policies and procedures regarding processing requests for exceptions to its cost-sharing structure to include the following: (1) A provision stating that DHMP will clearly identify the type of information that must be submitted when additional supporting medical documentation is requested, (2) A provision stating that DHMP must not keep an exceptions request open indefinitely when a physician does not submit a supporting statement, and (3) A provision stating that if DHMP is waiting on a physician's statement in support of a tiering exception request, DHMP must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	DHMP must update its policies and procedures regarding processing requests for exceptions for non-formulary drugs to include the following: (1) A provision stating that DHMP must not keep an exceptions request open indefinitely when a physician does not submit a supporting statement, and (2) A provision stating that if DHMP is waiting on a physician's statement in support of a formulary exception request, DHMP must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception.	Closed

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Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	DHMP must update its policies and procedures regarding determining cost-sharing for approved exceptions to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	(1) DHMP must submit to CMS its policies and procedures for categorization of cases as inquiries, grievances, or coverage determinations. (2) DHMP must submit to CMS a notice template for informing enrollees about inquiries involving excluded drugs.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	(1) DHMP must incorporate language into its policies and procedures describing prompt, appropriate action, including a full investigation of grievances if necessary. (2) DHMP must incorporate language in its policies and procedures describing its grievance tracking to include at a minimum, the date of receipt, disposition of the grievance, and the date the enrollee was notified of the disposition.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	(1) DHMP must submit to CMS its policies and procedures regarding training on its grievance process. (2) DHMP must provide documentation of its next training for staff and/or contractors on the grievance process that includes an attendance log and a description of the content.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	(1) DHMP must submit to CMS its policies and procedures describing cooperation with the QIO on grievance cases related to the quality of care. (2) DHMP must provide a notice template that is used to inform beneficiaries of the disposition of grievances and the right to file a Quality of Care complaint with the QIO.	Closed

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Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Denver Health must update their policies and procedures to include the following provisions: (1) provision stating that Denver Health automatically expedites a request when the enrollee¿s physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function, and (2) provision stating that any additional medical information Denver Health requires must be requested within 24 hours of receiving the initial request for expedited determination. Revised policies and procedures must be submitted to CMS.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Denver Health must update their policies and procedures to include a provision stating that Denver Health must transfer a denied request for an expedited redetermination to the standard redetermination timeframe. Denver Health must use a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance, for notifying an enrollee that a request for an expedited redetermination is denied. Revised policies and procedures, and the notice template, must be submitted to CMS.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Denver Health must update their policies and procedures to include a provision stating that Denver Health must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Denver Health must use a notice consistent with CMS-issued model notice, Request for Reconsideration, for enrollees requesting reconsiderations. Denver Health must have a notice template for enrollee notification when a request is forwarded to the IRE. Revised policies and procedures, and the notice templates, must be submitted to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Denver Health must update their policies and procedures to include a provision stating that Denver Health must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Denver Health must use a notice consistent with CMS-issued model notice, Request for Reconsideration, for enrollees requesting reconsiderations. Denver Health must have a notice template for enrollee notification when a request is forwarded to the IRE. Revised policies and procedures, and the notice templates, must be submitted to CMS.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Denver Health must update policies and procedures to include the following provisions: (1) provision indicating that notification of a favorable decision may be made orally or in writing, (2) provision indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, (3) provision stating that medical information must be requested within 24 hours of the enrollee¿s initial request, and (4) provision stating that Denver Health must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Denver Health must use a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance, for enrollee notification of an adverse expedited redetermination. Denver Health must use a notice consistent with CMS-issued model notice, Request for Reconsideration, for enrollees requesting reconsiderations. Denver Health must have a notice template for enrollee notification when request is forwarded to the IRE. Revised policies and procedures, and the notice templates, must be submitted to CMS.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Denver Health must update policies and procedures to include the following provisions: (1) provision stating that case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file, and (2) provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. Revised policies and procedures must be submitted to CMS.	Closed

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Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Denver Health must update policies and procedures to include provisions for effectuating third party reversals on an appeal of a request for a benefit. Denver Health must use a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity, for notifying the IRE of effectuation of a decision. Revised policies and procedures, and the notice template, must be submitted to CMS.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Denver Health must update policies and procedures to include provisions for effectuating third party reversals on an appeal of a request for payment. Denver Health must use a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity, for notifying the IRE of effectuation of a decision. Revised policies and procedures, and the notice template, must be submitted to CMS.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA-PD	Audit Findings	1/30/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Denver Health must update policies and procedures to include provisions for effectuating third party reversals on an appeal of an expedited request for a benefit. Denver Health must use a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity, for notifying the IRE of effectuation of a decision. Revised policies and procedures, and the notice template, must be submitted to CMS.	Closed

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Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA	Audit Findings	1/30/2008	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The Plan must develop a program that ensures that agents/brokers are adequately trained, monitored, and evaluated. The program should include: * Initial new hire training manual * Type and content of all subsequent trainings * How Plan will ensure knowledge and understanding of program requirements * If written tests are implemented, indicate expected answers, passing score, number of times a test can be taken and how you will re-educate on deficient areas * A process for ensuring that agents/brokers are informed of current program updates The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The program should include documentation in each agent/broker file of at least the following: * Evidence of current licensure * Date of hire * Evidence of attendance at trainings * Evidence of knowledge and understanding of Medicare and the Plan * Evaluation of presentation skills * Information regarding rapid disenrollment * Information about any sales complaints from current or prospective members * Information regarding disciplinary actions * Evidence of continued monitoring * Evidence of annual evaluation * Salary structure Create and/or revise policies to accurately reflect current practice. Develop a presentation assessment form. Monitor and document, in agent files, rapid disenrollments and disenrollment reasons. Describe how disenrollments will be monitored, frequency of monitoring and how the information will be utilized to monitor agent effectiveness.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA	Audit Findings	1/30/2008	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Develope a Policy and Procedure that states that the Plan will make a good faith effort to give members 30 days notice for all provider terminations. Describe the process for staff training and implementation.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA	Audit Findings	1/30/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	In order to demonstrate compliance with Credentialing requirements for physicians and other health care professionals, Denver Health must establish a Quality Improvement process which encompasses a formal process for reviewing performance indicators including: utilization management system, grievance system, enrollee satisfaction surveys, and other activities of the organization. The quality improvement process should be included in policies and procedures for both DHHA and UPI.	Closed

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Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA	Audit Findings	1/30/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Denver Health must conduct training of appropriate staff on the identification of grievances. Specifically, Denver health should ensure that staff understand the proper distinction between grievances and appeals and the appropriate categorization of both. Denver Health should submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Denver Health should conduct an internal audit of the grievances received. This audit should evaluate whether the grievances were appropriately catogorized and processed timely. The plan should submit a summary report to the Regional Office of its findings during the first six months of 2008. In addition, Denver Helath must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA	Audit Findings	1/30/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Denver Health must describe the actions it is taking to ensure that the notices sent members after investigating a complaint include a clear description of the final disposition, as appropriate. Denver Health must send the Regional Office copies of grievances and corresponding notices for three cases received after the staff has been trained to include a complete resolution in the notice. Release Updatee - (7/3/2008) - The plan provided the three grievance examples for review and they are now complete.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA	Audit Findings	1/30/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Denver Health must either revise the verbiage of the denial messages generated on the explanation of benefits (EOBs) or send an individual notice of denial of payment for the denied claim. Medicare Advantage Organizations must use Form No. CMS-10003-NDP. The language explaining the denial that is provided to the beneficiary must be clear and easily understood. Denver Health must also include the CMS approved appeal rights language along with the notice of denial.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA	Audit Findings	1/30/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Denver Health must develop policies and procedures, in accordance with CMS requirements, to be used when Denver Health receives a member appeal of a denied claim for which the member is financially liable.	Closed
Denver Healthcare Hospital Authority	1-303-602-7020	H5608	MA	Audit Findings	1/30/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	Denver Health must analyze its processes and take necessary action to ensure that authorizations for services reversed upon reconsideration are issued within the required timeframe. Corrective action submitted to the Regional Office should include the results of Denver Health¿s analysis as to the cause(s) of the delay, steps Denver Health is taking to correct the process, and a description of how it will monitor its compliance with this requirement.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Open

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its 'Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement	Open

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027- 'Medicare Part D - Coverage Determination and Exceptions Process': CW 'MM-AP-109 'Medicare Part D Prescription Drug Appeals': CPS 028 'Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Open

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 'Medicare Part D Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D-Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS	Closed

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled 'Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Open
Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Humana Inc.	1-502-580-3683	H2949	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Molina Healthcare must develop and implement policies and procedures to include the following regarding formulary change notices: 1) A provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization management tools to a drug at least 60 days prior to the date the change becomes effective. Also, include a provision to provide retrospective notice of formulary change because a Part D covered drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. 2) A description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on each affected plan's internet website. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Submit 10 samples of notices regarding formulary changes on worksheet WS_MR4_D.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Revise Policy and Procedure to include a description of the procedures for providing retrospective notice for drugs deemed unsafe by the FDA or removed from the market by the manufacturer. An example would be a Template Notice of Formulary or Cost-Sharing change, a list of covered Part D drugs removed from formulary, a sample of notices sent, or beneficiary communication logs.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Consideration of the Therapeutic Advantages of Prescription Drugs - The P&T Committee must consider whether the inclusion of a particular Part D drug in a formulary or formulary tier has any therapeutic advantages in terms of safety and efficacy.	Revise Pharmacy and Therapeutic Committee meeting minutes, or other documentation to show if Pharmacy and Therapeutics committee considers inclusion of a particular Part D drug on the formulary based on therapeutic advantages in terms of safety and efficacy. Additionally, document discussions of formulary or formulary tier placement. Submit documentation of committee discussion to ensure the above criteria will be reviewed, included, and placed into Pharmacy and Therapeutics committee meeting minutes. Submit committee meeting minutes to CMS for review from the next 2 quarterly meetings to ensure compliance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Evaluation of Part D Sponsor¿s Plan Treatment Protocols - The P&T Committee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products, at least annually in accordance with CMS requirements.	Pharmacy and Therapeutic Committee meeting minutes, or other documentation, should capture Pharmacy and Therapeutic Committee's evaluation, analysis and recommendations on treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products. Pharmacy and Therapeutic Committee review treatment protocols and procedures on at least an annual basis. Provide a sample to CMS from the next committee meeting showing evaluation of treatment protocols and how Molina will ensure they will be reviewed annually.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Approval of Therapeutic Classes - The P&T Committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis.	Pharmacy and Therapeutic Committee review and approve the inclusion or exclusion of therapeutic classes in the formulary on at least an annual basis, and document the review. Submit Pharmacy and Therapeutics meeting minutes from next meeting to ensure approval of inclusion or exclusion of therapeutic classes onto the formulary and documentation to ensure it will be reviewed on an annual basis.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Molina Healthcare must provide CMS with documentation that it arranges with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist by providing the following: (1) Policies and procedures that contain provisions for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist and (2) Policies and procedures that contain provisions for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Molina Healthcare must submit to CMS policies and procedures that (1) define "coverage determination" in accordance with § 423.566(b)(1-5), that (2) include provisions for tracking and addressing all requests for redeterminations, and that (3) include a provision for quarterly reporting of required data.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina must provide CMS with the following: (1) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, and (2) Monthly coverage determination case files until sufficient evidence is documented that Molina Healthcare makes timely coverage determinations.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures that contain a provision stating that Molina Healthcare must authorize payment within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (2) Policies and procedures that contain a provision stating that Molina Healthcare must must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and (3) A notice template for enrollee notification when request is forwarded to the IRE that is consistent with CMS-issued model notice, Notice of Case Status.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Molina Healthcare must submit to CMS a notice template used to notify enrollees of an adverse coverage determination.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations that identify the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, or a facsimile number to facilitate receipt of requests for expedited coverage determinations. (2) Policies and procedures indicating that all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. (3) Policies and procedures that discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. (4) Monthly expedited coverage determination case files until sufficient evidence is documented that decisions to expedite coverage determination requests are made correctly.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that denied requests to expedite a coverage determination is automatically transferred to the standard coverage determination process. (2) Policies and procedures that give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notices are sent to enrollees following denials of expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Molina Healthcare must submit to CMS the following: Policies and procedures regarding enrollee notification following a decision to deny requests for expedited coverage determinations that include (1) A provision stating that oral and written notice must provide an explanation that Molina Healthcare must process the request using the 72 hour timeframe for standard determinations. (2) A provision stating that oral and written notice must inform the enrollee of the right to file an expedited grievance. (3) A provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. (4) A provision stating that oral and written notice must provide instructions about Molina Healthcare's grievance process and its timeframes. Molina Healthcare must also submit to CMS monthly expedited coverage determination case files until sufficient evidence is documented that proper notifices are being sent to enrollees following a decision to deny requests for expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must submit to CMS the following (1) Policies and procedures that include a provision stating that Molina Healthcare must inform the enrollee within 24 hours when their requested in forwarded to the Independent Review Entity (IRE). (2) Documentation that Molina Healthcare uses a notice consistent with CMSissued model notice, Notice of Case Status, for cases that are forwarded to the IRE.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that if the decision is adverse, then Molina Healthcare must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. (2) Policies and procedures that include a provision stating that if oral notice is provided for an adverse decision, the notices must: * States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. * Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. * Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notice is provided to enrollees concerning expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must develop policies and procedures regarding processing requests to its tiered cost-sharing structure whether there are 2 or 4 tiers. The exception process must include but not limited to: 1) A provision that allows an enrollee an appointed representative to file an exception request. 2) A provision stating if the the plan requires a written statement for exception. 3) A provision from the prescribing physician indicating the drug for treatment would not be effective as the requested drug and/or would have adverse effects. 4) A provision stating additional supporting medical documentation may be required for approval. 5) A provision stating Molina Healthcare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. 6) A provision stating that Molina Healthcare is waiting on a physician's statement in support of a tiering exception and must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing a determination on tiering exception. 7) A provision granting a tiering exception when it is determined that the drug for treatment of the enrollee's condition wuld not be as effective for the enrollee as the requested drug and/or would have adverse effects. A 2-tiered formulary must include a statement to the exception process indicating that Molina Healthcare only has 2 tiers, therefore a tiering exception is not necessary. Additionally, Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must revise its policies and procedures to include a provision stating: 1) An enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception. 2) The prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be efffective because all covered Part D drugs on any tier would not be as effective, clinical evidence would indicate the current drug regimen is ineffective or adversely affect effectiveness or patient compliance, prescription alternative(s) on formulary have been ineffective. 3) If Molina Healthcare makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. 4) Exception requests must not be kept open indefinitely when a physician does not submit a supporting statement. 5) If Molina Healthcare is waiting on a physician's statement in support of a formulary exception request, they must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. 5)Molina Healthcare must grant a formulary exception when it determines that one of the three factors discussed in Number 2 above have been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. 6) Molina Healthcare does not restrict the number of exception requests submitted per enrollee. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Refer to Section 30.2 (Exceptions) in Chapter 18 of the Prescription Drug Manual for guidance. The notice template in Appendix 11 in the same chapter, although intended for members, may be helpful in developing a notice for requesting information from prescribing physicians.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Molina Healthcare must develop and implement policies and procedures regarding Approval of Tiering and Non-formulary Exceptions Requests. Provisions in the policies must include: 1) Coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. 2) Enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. 3) All approved non-formulary drugs must be placed in existing cost-sharing tier(s). Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina Healthcare must provide an analysis and explanation of why the universe submitted for WS-CD2_D contained no information. Provide CMS with a detailed corrective action plan to ensure that this element and universe population will be met consistently.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	The Plan needs to develop and submit phone scripts, enrollee notices informing members whether their complaints are grievances or coverage determinations, and the Notice of Inquiry Regarding an Excluded Drugs. Please explain how staff have been updated and trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe the minimum grievance data to be maintained and a record retention time frame of 10 years. Please refer to 42 CFR 423.456(g) and 42 CFR 423.505(e). The Policy must also state that the Plan will take prompt appropriate action including a full investigation of the complaint.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe how the Plan will train relevant staff. Please describe in detail how staff are trained and monitored.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Please update the policy to reflect that when the Plan decides to extend the response deadline it will notify beneficiaries the same day or as soon as possible. Please submit the Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	On page 3 of the grievance Policy and Procedure, section 2 refers to expediting a grievance related to provider availability. There is no such provision for expedited grievances. The two examples under this paragraph are correct. Please eliminate the references to provider availability being a reason for an expedited grievance. Section 6 in this policy and procedure refers to notifying the beneficiary within 30 days. Expedited grievances must be responded to within 24 hours. Please correct the Plan response time frames for expedited grievances.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Molina Healthcare must revise its policies and procedures to include a provision for accepting written requests for standard redetermination of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination. Molina must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Molina must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Molina Healthcare must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Molina must provide CMS with documentation demonstrating its system for maintaining documentation of expedited redetermination requests in case files, accepting requests for expedited redeterminations, and documenting all oral requests in writing. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must revise its policies and procedures to include provisions stating: - Molina must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - Molina must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Molina must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing. - indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification. - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. - stating that Molina must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Molina Healthcare must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72-hour timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Molina has a system for expedited coverage determination reversals.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Molina Healthcare must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Molina must revise its policies and procedures to include a provision stating that if the issue is denial based on lack of medical necessity, then Molina must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina uses appropriate personnel to conduct redeterminations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Molina must revise its policies and procedures to include a provision stating: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax to its designated fax number. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina forwards untimely cases to the IRE.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision. - requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Molina Healthcare must develop and implement policies and procedures to include the following regarding formulary change notices: 1) A provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization management tools to a drug at least 60 days prior to the date the change becomes effective. Also, include a provision to provide retrospective notice of formulary change because a Part D covered drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. 2) A description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on each affected plan's internet website. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Submit 10 samples of notices regarding formulary changes on worksheet WS_MR4_D.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Revise Policy and Procedure to include a description of the procedures for providing retrospective notice for drugs deemed unsafe by the FDA or removed from the market by the manufacturer. An example would be a Template Notice of Formulary or Cost-Sharing change, a list of covered Part D drugs removed from formulary, a sample of notices sent, or beneficiary communication logs.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Consideration of the Therapeutic Advantages of Prescription Drugs - The P&T Committee must consider whether the inclusion of a particular Part D drug in a formulary or formulary tier has any therapeutic advantages in terms of safety and efficacy.	Revise Pharmacy and Therapeutic Committee meeting minutes, or other documentation to show if Pharmacy and Therapeutics committee considers inclusion of a particular Part D drug on the formulary based on therapeutic advantages in terms of safety and efficacy. Additionally, document discussions of formulary or formulary tier placement. Submit documentation of committee discussion to ensure the above criteria will be reviewed, included, and placed into Pharmacy and Therapeutics committee meeting minutes. Submit committee meeting minutes to CMS for review from the next 2 quarterly meetings to ensure compliance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Evaluation of Part D Sponsor¿s Plan Treatment Protocols - The P&T Committee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products, at least annually in accordance with CMS requirements.	Pharmacy and Therapeutic Committee meeting minutes, or other documentation, should capture Pharmacy and Therapeutic Committee's evaluation, analysis and recommendations on treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products. Pharmacy and Therapeutic Committee review treatment protocols and procedures on at least an annual basis. Provide a sample to CMS from the next committee meeting showing evaluation of treatment protocols and how Molina will ensure they will be reviewed annually.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Approval of Therapeutic Classes - The P&T Committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis.	Pharmacy and Therapeutic Committee review and approve the inclusion or exclusion of therapeutic classes in the formulary on at least an annual basis, and document the review. Submit Pharmacy and Therapeutics meeting minutes from next meeting to ensure approval of inclusion or exclusion of therapeutic classes onto the formulary and documentation to ensure it will be reviewed on an annual basis.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Molina Healthcare must provide CMS with documentation that it arranges with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist by providing the following: (1) Policies and procedures that contain provisions for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist and (2) Policies and procedures that contain provisions for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Molina Healthcare must submit to CMS policies and procedures that (1) define "coverage determination" in accordance with § 423.566(b)(1-5), that (2) include provisions for tracking and addressing all requests for redeterminations, and that (3) include a provision for quarterly reporting of required data.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina must provide CMS with the following: (1) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, and (2) Monthly coverage determination case files until sufficient evidence is documented that Molina Healthcare makes timely coverage determinations.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures that contain a provision stating that Molina Healthcare must authorize payment within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (2) Policies and procedures that contain a provision stating that Molina Healthcare must must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and (3) A notice template for enrollee notification when request is forwarded to the IRE that is consistent with CMS-issued model notice, Notice of Case Status.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Molina Healthcare must submit to CMS a notice template used to notify enrollees of an adverse coverage determination.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations that identify the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, or a facsimile number to facilitate receipt of requests for expedited coverage determinations. (2) Policies and procedures indicating that all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. (3) Policies and procedures that discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. (4) Monthly expedited coverage determination case files until sufficient evidence is documented that decisions to expedite coverage determination requests are made correctly.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that denied requests to expedite a coverage determination is automatically transferred to the standard coverage determination process. (2) Policies and procedures that give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notices are sent to enrollees following denials of expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Molina Healthcare must submit the following to CMS: Policies and procedures regarding enrollee notification following a decision to deny requests for expedited coverage determinations that include (1) A provision stating that oral and written notice must provide an explanation that Molina Healthcare must process the request using the 72 hour timeframe for standard determinations. (2) A provision stating that oral and written notice must inform the enrollee of the right to file an expedited grievance. (3) A provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. (4) A provision stating that oral and written notice must provide instructions about Molina Healthcare's grievance process and its timeframes. Molina Healthcare must also submit to CMS monthly expedited coverage determination case files until sufficient evidence is documented that proper notifices are being sent to enrollees following a decision to deny requests for expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must submit to CMS the following (1) Policies and procedures that include a provision stating that Molina Healthcare must inform the enrollee within 24 hours when their request is forwarded to the Independent Review Entity (IRE). (2) Documentation that Molina Healthcare uses a notice consistent with CMS issued model notice, Notice of Case Status, for cases that are forwarded to the IRE.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that if the decision is adverse, then Molina Healthcare must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. (2) Policies and procedures that include a provision stating that if oral notice is provided for an adverse decision, the notices must: * States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. * Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. * Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notice is provided to enrollees concerning expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must develop policies and procedures regarding processing requests to its tiered cost-sharing structure whether there are 2 or 4 tiers. The exception process must include but not limited to: 1) A provision that allows an enrollee an appointed representative to file an exception request. 2) A provision stating if the the plan requires a written statement for exception. 3) A provision from the prescribing physician indicating the drug for treatment would not be effective as the requested drug and/or would have adverse effects. 4) A provision stating additional supporting medical documentation may be required for approval. 5) A provision stating Molina Healthcare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. 6) A provision stating that Molina Healthcare is waiting on a physician's statement in support of a tiering exception and must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing a determination on tiering exception. 7) A provision granting a tiering exception when it is determined that the drug for treatment of the enrollee's condition wuld not be as effective for the enrollee as the requested drug and/or would have adverse effects. A 2-tiered formulary must include a statement to the exception process indicating that Molina Healthcare only has 2 tiers, therefore a tiering exception is not necessary. Additionally, Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must revise its policies and procedures to include a provision stating: 1) An enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception. 2) The prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be efffective because all covered Part D drugs on any tier would not be as effective, clinical evidence would indicate the current drug regimen is ineffective or adversely affect effectiveness or patient compliance, prescription alternative(s) on formulary have been ineffective. 3) If Molina Healthcare makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. 4) Exception requests must not be kept open indefinitely when a physician does not submit a supporting statement. 5) If Molina Healthcare is waiting on a physician's statement in support of a formulary exception request, they must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. 5)Molina Healthcare must grant a formulary exception when it determines that one of the three factors discussed in Number 2 above have been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. 6) Molina Healthcare does not restrict the number of exception requests submitted per enrollee. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Refer to Section 30.2 (Exceptions) in Chapter 18 of the Prescription Drug Manual for guidance. The notice template in Appendix 11 in the same chapter, although intended for members, may be helpful in developing a notice for requesting information from prescribing physicians.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Molina Healthcare must develop and implement policies and procedures regarding Approval of Tiering and Non-formulary Exceptions Requests. Provisions in the policies must include: 1) Coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. 2) Enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. 3) All approved non-formulary drugs must be placed in existing cost-sharing tier(s). Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina Healthcare must provide an analysis and explanation of why the universe submitted for WS-CD2_D contained no information. Provide CMS with a detailed corrective action plan to ensure that this element and universe population will be met consistently.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	The Plan needs to develop and submit phone scripts, enrollee notices informing members whether their complaints are grievances or coverage determinations, and the Notice of Inquiry Regarding an Excluded Drugs. Please explain how staff have been updated and trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe the minimum grievance data to be maintained and a record retention time frame of 10 years. Please refer to 42 CFR 423.456(g) and 42 CFR 423.505(e). The Policy must also state that the Plan will take prompt appropriate action including a full investigation of the complaint.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe how the Plan will train relevant staff. Please describe in detail how staff are trained and monitored.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Please update the policy to reflect that when the Plan decides to extend the response deadline it will notify beneficiaries the same day or as soon as possible. Please submit the Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	On page 3 of the grievance Policy and Procedure, section 2 refers to expediting a grievance related to provider availability. There is no such provision for expedited grievances. The two examples under this paragraph are correct. Please eliminate the references to provider availability being a reason for an expedited grievance. Section 6 in this policy and procedure refers to notifying the beneficiary within 30 days. Expedited grievances must be responded to within 24 hours. Please correct the Plan response time frames for expedited grievances.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Molina Healthcare must revise its policies and procedures to include a provision for accepting written requests for standard redetermination of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination. Molina must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Molina must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Molina Healthcare must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Molina must provide CMS with documentation demonstrating its system for maintaining documentation of expedited redetermination requests in case files, accepting requests for expedited redeterminations, and documenting all oral requests in writing. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must revise its policies and procedures to include provisions stating: - Molina must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - Molina must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Molina must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing. - indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification. - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. - stating that Molina must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Molina Healthcare must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72-hour timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Molina has a system for expedited coverage determination reversals.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Molina Healthcare must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Molina must revise its policies and procedures to include a provision stating that if the issue is denial based on lack of medical necessity, then Molina must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina uses appropriate personnel to conduct redeterminations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Molina must revise its policies and procedures to include a provision stating: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax to its designated fax number. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina forwards untimely cases to the IRE.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision. - requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Molina Healthcare must develop and implement policies and procedures to include the following regarding formulary change notices: 1) A provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization management tools to a drug at least 60 days prior to the date the change becomes effective. Also, include a provision to provide retrospective notice of formulary change because a Part D covered drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. 2) A description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on each affected plan's internet website. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Submit 10 samples of notices regarding formulary changes on worksheet WS_MR4_D.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Revise Policy and Procedure to include a description of the procedures for providing retrospective notice for drugs deemed unsafe by the FDA or removed from the market by the manufacturer. An example would be a Template Notice of Formulary or Cost-Sharing change, a list of covered Part D drugs removed from formulary, a sample of notices sent, or beneficiary communication logs.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Consideration of the Therapeutic Advantages of Prescription Drugs - The P&T Committee must consider whether the inclusion of a particular Part D drug in a formulary or formulary tier has any therapeutic advantages in terms of safety and efficacy.	Revise Pharmacy and Therapeutic Committee meeting minutes, or other documentation to show if Pharmacy and Therapeutics committee considers inclusion of a particular Part D drug on the formulary based on therapeutic advantages in terms of safety and efficacy. Additionally, document discussions of formulary or formulary tier placement. Submit documentation of committee discussion to ensure the above criteria will be reviewed, included, and placed into Pharmacy and Therapeutics committee meeting minutes. Submit committee meeting minutes to CMS for review from the next 2 quarterly meetings to ensure compliance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Evaluation of Part D Sponsor¿s Plan Treatment Protocols - The P&T Committee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products, at least annually in accordance with CMS requirements.	Pharmacy and Therapeutic Committee meeting minutes, or other documentation, should capture Pharmacy and Therapeutic Committee's evaluation, analysis and recommendations on treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products. Pharmacy and Therapeutic Committee review treatment protocols and procedures on at least an annual basis. Provide a sample to CMS from the next committee meeting showing evaluation of treatment protocols and how Molina will ensure they will be reviewed annually.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Approval of Therapeutic Classes - The P&T Committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis.	Pharmacy and Therapeutic Committee review and approve the inclusion or exclusion of therapeutic classes in the formulary on at least an annual basis, and document the review. Submit Pharmacy and Therapeutics meeting minutes from next meeting to ensure approval of inclusion or exclusion of therapeutic classes onto the formulary and documentation to ensure it will be reviewed on an annual basis.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Molina Healthcare must provide CMS with documentation that it arranges with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist by providing the following: (1) Policies and procedures that contain provisions for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist and (2) Policies and procedures that contain provisions for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Molina Healthcare must submit to CMS policies and procedures that (1) define "coverage determination" in accordance with § 423.566(b)(1-5), that (2) include provisions for tracking and addressing all requests for redeterminations, and that (3) include a provision for quarterly reporting of required data.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina must provide CMS with the following: (1) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, and (2) Monthly coverage determination case files until sufficient evidence is documented that Molina Healthcare makes timely coverage determinations.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures that contain a provision stating that Molina Healthcare must authorize payment within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (2) Policies and procedures that contain a provision stating that Molina Healthcare must must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and (3) A notice template for enrollee notification when request is forwarded to the IRE that is consistent with CMS-issued model notice, Notice of Case Status.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Molina Healthcare must submit to CMS a notice template used to notify enrollees of an adverse coverage determination.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations that identify the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, or a facsimile number to facilitate receipt of requests for expedited coverage determinations. (2) Policies and procedures indicating that all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. (3) Policies and procedures that discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. (4) Monthly expedited coverage determination case files until sufficient evidence is documented that decisions to expedite coverage determination requests are made correctly.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that denied requests to expedite a coverage determination is automatically transferred to the standard coverage determination process. (2) Policies and procedures that give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notices are sent to enrollees following denials of expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Molina Healthcare must submit to CMS the following: Policies and procedures regarding enrollee notification following a decision to deny requests for expedited coverage determinations that include (1) A provision stating that oral and written notice must provide an explanation that Molina Healthcare must process the request using the 72 hour timeframe for standard determinations. (2) A provision stating that oral and written notice must inform the enrollee of the right to file an expedited grievance. (3) A provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. (4) A provision stating that oral and written notice must provide instructions about Molina Healthcare's grievance process and its timeframes. Molina Healthcare must also submit to CMS monthly expedited coverage determination case files until sufficient evidence is documented that proper notifices are being sent to enrollees following a decision to deny requests for expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must submit to CMS the following (1) Policies and procedures that include a provision stating that Molina Healthcare must inform the enrollee within 24 hours when their requested in forwarded to the Independent Review Entity (IRE). (2) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, for cases that are forwarded to the IRE.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that if the decision is adverse, then Molina Healthcare must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. (2) Policies and procedures that include a provision stating that if oral notice is provided for an adverse decision, the notices must: * States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. * Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. * Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notice is provided to enrollees concerning expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must develop policies and procedures regarding processing requests to its tiered cost-sharing structure whether there are 2 or 4 tiers. The exception process must include but not limited to: 1) A provision that allows an enrollee an appointed representative to file an exception request. 2) A provision stating if the the plan requires a written statement for exception. 3) A provision from the prescribing physician indicating the drug for treatment would not be effective as the requested drug and/or would have adverse effects. 4) A provision stating additional supporting medical documentation may be required for approval. 5) A provision stating Molina Healthcare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. 6) A provision stating that Molina Healthcare is waiting on a physician's statement in support of a tiering exception and must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing a determination on tiering exception. 7) A provision granting a tiering exception when it is determined that the drug for treatment of the enrollee's condition wuld not be as effective for the enrollee as the requested drug and/or would have adverse effects. A 2-tiered formulary must include a statement to the exception process indicating that Molina Healthcare only has 2 tiers, therefore a tiering exception is not necessary. Additionally, Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must revise its policies and procedures to include a provision stating: 1) An enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception. 2) The prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be efffective because all covered Part D drugs on any tier would not be as effective, clinical evidence would indicate the current drug regimen is ineffective or adversely affect effectiveness or patient compliance, prescription alternative(s) on formulary have been ineffective. 3) If Molina Healthcare makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. 4) Exception requests must not be kept open indefinitely when a physician does not submit a supporting statement. 5) If Molina Healthcare is waiting on a physician's statement in support of a formulary exception request, they must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. 5)Molina Healthcare must grant a formulary exception when it determines that one of the three factors discussed in Number 2 above have been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. 6) Molina Healthcare does not restrict the number of exception requests submitted per enrollee. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Refer to Section 30.2 (Exceptions) in Chapter 18 of the Prescription Drug Manual for guidance. The notice template in Appendix 11 in the same chapter, although intended for members, may be helpful in developing a notice for requesting information from prescribing physicians.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Molina Healthcare must develop and implement policies and procedures regarding Approval of Tiering and Non-formulary Exceptions Requests. Provisions in the policies must include: 1) Coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. 2) Enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. 3) All approved non-formulary drugs must be placed in existing cost-sharing tier(s). Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina Healthcare must provide an analysis and explanation of why the universe submitted for WS-CD2_D contained no information. Provide CMS with a detailed corrective action plan to ensure that this element and universe population will be met consistently.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	The Plan needs to develop and submit phone scripts, enrollee notices informing members whether their complaints are grievances or coverage determinations, and the Notice of Inquiry Regarding an Excluded Drugs. Please explain how staff have been updated and trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe the minimum grievance data to be maintained and a record retention time frame of 10 years. Please refer to 42 CFR 423.456(g) and 42 CFR 423.505(e). The Policy must also state that the Plan will take prompt appropriate action including a full investigation of the complaint.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe how the Plan will train relevant staff. Please describe in detail how staff are trained and monitored.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Please update the policy to reflect that when the Plan decides to extend the response deadline it will notify beneficiaries the same day or as soon as possible. Please submit the Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	On page 3 of the grievance Policy and Procedure, section 2 refers to expediting a grievance related to provider availability. There is no such provision for expedited grievances. The two examples under this paragraph are correct. Please eliminate the references to provider availability being a reason for an expedited grievance. Section 6 in this policy and procedure refers to notifying the beneficiary within 30 days. Expedited grievances must be responded to within 24 hours. Please correct the Plan response time frames for expedited grievances.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Molina Healthcare must revise its policies and procedures to include a provision for accepting written requests for standard redetermination of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination. Molina must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Molina must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Molina Healthcare must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Molina must provide CMS with documentation demonstrating its system for maintaining documentation of expedited redetermination requests in case files, accepting requests for expedited redeterminations, and documenting all oral requests in writing. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must revise its policies and procedures to include provisions stating: - Molina must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - Molina must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Molina must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing. - indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification. - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. - stating that Molina must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Molina Healthcare must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72-hour timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Molina has a system for expedited coverage determination reversals.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Molina Healthcare must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Molina must revise its policies and procedures to include a provision stating that if the issue is denial based on lack of medical necessity, then Molina must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina uses appropriate personnel to conduct redeterminations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Molina must revise its policies and procedures to include a provision stating: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax to its designated fax number. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina forwards untimely cases to the IRE.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision. - requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Molina Healthcare must develop and implement policies and procedures to include the following regarding formulary change notices: 1) A provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization management tools to a drug at least 60 days prior to the date the change becomes effective. Also, include a provision to provide retrospective notice of formulary change because a Part D covered drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. 2) A description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on each affected plan's internet website. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Submit 10 samples of notices regarding formulary changes on worksheet WS_MR4_D.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Revise Policy and Procedure to include a description of the procedures for providing retrospective notice for drugs deemed unsafe by the FDA or removed from the market by the manufacturer. An example would be a Template Notice of Formulary or Cost-Sharing change, a list of covered Part D drugs removed from formulary, a sample of notices sent, or beneficiary communication logs.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Consideration of the Therapeutic Advantages of Prescription Drugs - The P&T Committee must consider whether the inclusion of a particular Part D drug in a formulary or formulary tier has any therapeutic advantages in terms of safety and efficacy.	Revise Pharmacy and Therapeutic Committee meeting minutes, or other documentation to show if Pharmacy and Therapeutics committee considers inclusion of a particular Part D drug on the formulary based on therapeutic advantages in terms of safety and efficacy. Additionally, document discussions of formulary or formulary tier placement. Submit documentation of committee discussion to ensure the above criteria will be reviewed, included, and placed into Pharmacy and Therapeutics committee meeting minutes. Submit committee meeting minutes to CMS for review from the next 2 quarterly meetings to ensure compliance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Evaluation of Part D Sponsor¿s Plan Treatment Protocols - The P&T Committee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products, at least annually in accordance with CMS requirements.	Pharmacy and Therapeutic Committee meeting minutes, or other documentation, should capture Pharmacy and Therapeutic Committee's evaluation, analysis and recommendations on treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products. Pharmacy and Therapeutic Committee review treatment protocols and procedures on at least an annual basis. Provide a sample to CMS from the next committee meeting showing evaluation of treatment protocols and how Molina will ensure they will be reviewed annually.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Approval of Therapeutic Classes - The P&T Committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis.	Pharmacy and Therapeutic Committee review and approve the inclusion or exclusion of therapeutic classes in the formulary on at least an annual basis, and document the review. Submit Pharmacy and Therapeutics meeting minutes from next meeting to ensure approval of inclusion or exclusion of therapeutic classes onto the formulary and documentation to ensure it will be reviewed on an annual basis.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Molina Healthcare must provide CMS with documentation that it arranges with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist by providing the following: (1) Policies and procedures that contain provisions for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist and (2) Policies and procedures that contain provisions for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Molina Healthcare must submit to CMS policies and procedures that (1) define "coverage determination" in accordance with § 423.566(b)(1-5), that (2) include provisions for tracking and addressing all requests for redeterminations, and that (3) include a provision for quarterly reporting of required data.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina must provide CMS with the following: (1) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, and (2) Monthly coverage determination case files until sufficient evidence is documented that Molina Healthcare makes timely coverage determinations.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures that contain a provision stating that Molina Healthcare must authorize payment within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (2) Policies and procedures that contain a provision stating that Molina Healthcare must must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and (3) A notice template for enrollee notification when request is forwarded to the IRE that is consistent with CMS-issued model notice, Notice of Case Status.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Molina Healthcare must submit to CMS a notice template used to notify enrollees of an adverse coverage determination.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations that identify the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, or a facsimile number to facilitate receipt of requests for expedited coverage determinations. (2) Policies and procedures indicating that all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. (3) Policies and procedures that discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. (4) Monthly expedited coverage determination case files until sufficient evidence is documented that decisions to expedite coverage determination requests are made correctly.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that denied requests to expedite a coverage determination is automatically transferred to the standard coverage determination process. (2) Policies and procedures that give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notices are sent to enrollees following denials of expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Molina Healthcare must submit the following to CMS: Policies and procedures regarding enrollee notification following a decision to deny requests for expedited coverage determinations that include (1) A provision stating that oral and written notice must provide an explanation that Molina Healthcare must process the request using the 72 hour timeframe for standard determinations. (2) A provision stating that oral and written notice must inform the enrollee of the right to file an expedited grievance. (3) A provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. (4) A provision stating that oral and written notice must provide instructions about Molina Healthcare's grievance process and its timeframes. Molina Healthcare must also submit to CMS monthly expedited coverage determination case files until sufficient evidence is documented that proper notifices are being sent to enrollees following a decision to deny requests for expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must submit to CMS the following (1) Policies and procedures that include a provision stating that Molina Healthcare must inform the enrollee within 24 hours when their requested in forwarded to the Independent Review Entity (IRE). (2) Documentation that Molina Healthcare uses a notice consistent with CMSissued model notice, Notice of Case Status, for cases that are forwarded to the IRE.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that if the decision is adverse, then Molina Healthcare must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. (2) Policies and procedures that include a provision stating that if oral notice is provided for an adverse decision, the notices must: * States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. * Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. * Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notice is provided to enrollees concerning expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must develop policies and procedures regarding processing requests to its tiered cost-sharing structure whether there are 2 or 4 tiers. The exception process must include but not limited to: 1) A provision that allows an enrollee an appointed representative to file an exception request. 2) A provision stating if the the plan requires a written statement for exception. 3) A provision from the prescribing physician indicating the drug for treatment would not be effective as the requested drug and/or would have adverse effects. 4) A provision stating additional supporting medical documentation may be required for approval. 5) A provision stating Molina Healthcare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. 6) A provision stating that Molina Healthcare is waiting on a physician's statement in support of a tiering exception and must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing a determination on tiering exception. 7) A provision granting a tiering exception when it is determined that the drug for treatment of the enrollee's condition wuld not be as effective for the enrollee as the requested drug and/or would have adverse effects. A 2-tiered formulary must include a statement to the exception process indicating that Molina Healthcare only has 2 tiers, therefore a tiering exception is not necessary. Additionally, Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must revise its policies and procedures to include a provision stating: 1) An enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception. 2) The prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be efffective because all covered Part D drugs on any tier would not be as effective, clinical evidence would indicate the current drug regimen is ineffective or adversely affect effectiveness or patient compliance, prescription alternative(s) on formulary have been ineffective. 3) If Molina Healthcare makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. 4) Exception requests must not be kept open indefinitely when a physician does not submit a supporting statement. 5) If Molina Healthcare is waiting on a physician's statement in support of a formulary exception request, they must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. 5)Molina Healthcare must grant a formulary exception when it determines that one of the three factors discussed in Number 2 above have been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. 6) Molina Healthcare does not restrict the number of exception requests submitted per enrollee. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Refer to Section 30.2 (Exceptions) in Chapter 18 of the Prescription Drug Manual for guidance. The notice template in Appendix 11 in the same chapter, although intended for members, may be helpful in developing a notice for requesting information from prescribing physicians.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Molina Healthcare must develop and implement policies and procedures regarding Approval of Tiering and Non-formulary Exceptions Requests. Provisions in the policies must include: 1) Coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. 2) Enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. 3) All approved non-formulary drugs must be placed in existing cost-sharing tier(s). Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina Healthcare must provide an analysis and explanation of why the universe submitted for WS-CD2_D contained no information. Provide CMS with a detailed corrective action plan to ensure that this element and universe population will be met consistently.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	The Plan needs to develop and submit phone scripts, enrollee notices informing members whether their complaints are grievances or coverage determinations, and the Notice of Inquiry Regarding an Excluded Drugs. Please explain how staff have been updated and trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe the minimum grievance data to be maintained and a record retention time frame of 10 years. Please refer to 42 CFR 423.456(g) and 42 CFR 423.505(e). The Policy must also state that the Plan will take prompt appropriate action including a full investigation of the complaint.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe how the Plan will train relevant staff. Please describe in detail how staff are trained and monitored.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Please update the policy to reflect that when the Plan decides to extend the response deadline it will notify beneficiaries the same day or as soon as possible. Please submit the Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	On page 3 of the grievance Policy and Procedure, section 2 refers to expediting a grievance related to provider availability. There is no such provision for expedited grievances. The two examples under this paragraph are correct. Please eliminate the references to provider availability being a reason for an expedited grievance. Section 6 in this policy and procedure refers to notifying the beneficiary within 30 days. Expedited grievances must be responded to within 24 hours. Please correct the Plan response time frames for expedited grievances.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Molina Healthcare must revise its policies and procedures to include a provision for accepting written requests for standard redetermination of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination. Molina must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Molina must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Molina Healthcare must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Molina must provide CMS with documentation demonstrating its system for maintaining documentation of expedited redetermination requests in case files, accepting requests for expedited redeterminations, and documenting all oral requests in writing. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must revise its policies and procedures to include provisions stating: - Molina must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - Molina must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Molina must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing. - indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification. - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. - stating that Molina must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Molina Healthcare must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72-hour timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Molina has a system for expedited coverage determination reversals.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Molina Healthcare must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Molina must revise its policies and procedures to include a provision stating that if the issue is denial based on lack of medical necessity, then Molina must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina uses appropriate personnel to conduct redeterminations.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Molina must revise its policies and procedures to include a provision stating: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax to its designated fax number. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina forwards untimely cases to the IRE.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision. - requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Molina Healthcare must develop and implement policies and procedures to include the following regarding formulary change notices: 1) A provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization management tools to a drug at least 60 days prior to the date the change becomes effective. Also, include a provision to provide retrospective notice of formulary change because a Part D covered drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. 2) A description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on each affected plan's internet website. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Submit 10 samples of notices regarding formulary changes on worksheet WS_MR4_D.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Revise Policy and Procedure to include a description of the procedures for providing retrospective notice for drugs deemed unsafe by the FDA or removed from the market by the manufacturer. An example would be a Template Notice of Formulary or Cost-Sharing change, a list of covered Part D drugs removed from formulary, a sample of notices sent, or beneficiary communication logs.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Consideration of the Therapeutic Advantages of Prescription Drugs - The P&T Committee must consider whether the inclusion of a particular Part D drug in a formulary or formulary tier has any therapeutic advantages in terms of safety and efficacy.	Revise Pharmacy and Therapeutic Committee meeting minutes, or other documentation to show if Pharmacy and Therapeutics committee considers inclusion of a particular Part D drug on the formulary based on therapeutic advantages in terms of safety and efficacy. Additionally, document discussions of formulary or formulary tier placement. Submit documentation of committee discussion to ensure the above criteria will be reviewed, included, and placed into Pharmacy and Therapeutics committee meeting minutes. Submit committee meeting minutes to CMS for review from the next 2 quarterly meetings to ensure compliance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Evaluation of Part D Sponsor¿s Plan Treatment Protocols - The P&T Committee evaluates, analyzes and recommends treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products, at least annually in accordance with CMS requirements.	Pharmacy and Therapeutic Committee meeting minutes, or other documentation, should capture Pharmacy and Therapeutic Committee's evaluation, analysis and recommendations on treatment protocols and procedures for the timely use of and access to both formulary and non-formulary drug products. Pharmacy and Therapeutic Committee review treatment protocols and procedures on at least an annual basis. Provide a sample to CMS from the next committee meeting showing evaluation of treatment protocols and how Molina will ensure they will be reviewed annually.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Annual Approval of Therapeutic Classes - The P&T Committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis.	Pharmacy and Therapeutic Committee review and approve the inclusion or exclusion of therapeutic classes in the formulary on at least an annual basis, and document the review. Submit Pharmacy and Therapeutics meeting minutes from next meeting to ensure approval of inclusion or exclusion of therapeutic classes onto the formulary and documentation to ensure it will be reviewed on an annual basis.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Molina Healthcare must provide CMS with documentation that it arranges with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist by providing the following: (1) Policies and procedures that contain provisions for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist and (2) Policies and procedures that contain provisions for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Molina Healthcare must submit to CMS policies and procedures that (1) define "coverage determination" in accordance with § 423.566(b)(1-5), that (2) include provisions for tracking and addressing all requests for redeterminations, and that (3) include a provision for quarterly reporting of required data.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina must provide CMS with the following: (1) Documentation that Molina Healthcare uses a notice consistent with CMS-issued model notice, Notice of Case Status, and (2) Monthly coverage determination case files until sufficient evidence is documented that Molina Healthcare makes timely coverage determinations.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures that contain a provision stating that Molina Healthcare must authorize payment within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (2) Policies and procedures that contain a provision stating that Molina Healthcare must must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and (3) A notice template for enrollee notification when request is forwarded to the IRE that is consistent with CMS-issued model notice, Notice of Case Status.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Molina Healthcare must submit to CMS a notice template used to notify enrollees of an adverse coverage determination.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Molina Healthcare must submit the following to CMS: (1) Policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations that identify the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, or a facsimile number to facilitate receipt of requests for expedited coverage determinations. (2) Policies and procedures indicating that all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. (3) Policies and procedures that discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. (4) Monthly expedited coverage determination case files until sufficient evidence is documented that decisions to expedite coverage determination requests are made correctly.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision stating that denied requests to expedite a coverage determination is automatically transferred to the standard coverage determination process. (2) Policies and procedures that give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notices are sent to enrollees following denials of expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Molina Healthcare must submit to CMS the following: Policies and procedures regarding enrollee notification following a decision to deny requests for expedited coverage determinations that include (1) A provision stating that oral and written notice must provide an explanation that Molina Healthcare must process the request using the 72 hour timeframe for standard determinations. (2) A provision stating that oral and written notice must inform the enrollee of the right to file an expedited grievance. (3) A provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. (4) A provision stating that oral and written notice must provide instructions about Molina Healthcare's grievance process and its timeframes. Molina Healthcare must also submit to CMS monthly expedited coverage determination case files until sufficient evidence is documented that proper notifices are being sent to enrollees following a decision to deny requests for expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must submit to CMS the following (1) Policies and procedures that include a provision stating that Molina Healthcare must inform the enrollee within 24 hours when their requested in forwarded to the Independent Review Entity (IRE). (2) Documentation that Molina Healthcare uses a notice consistent with CMSissued model notice, Notice of Case Status, for cases that are forwarded to the IRE.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Molina Healthcare must submit to CMS the following: (1) Policies and procedures that include a provision statingthat if the decision is adverse, then Molina Healthcare must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. (2) Policies and procedures that include aprovision stating that if oral notice is provided for an adverse decision, the notices must: * States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. * Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. * Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. (3) Monthly expedited coverage determination case files until sufficient evidence is documented that proper notice is provided to enrollees concerning expedited coverage determinations.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must develop policies and procedures regarding processing requests to its tiered cost-sharing structure whether there are 2 or 4 tiers. The exception process must include but not limited to: 1) A provision that allows an enrollee an appointed representative to file an exception request. 2) A provision stating if the the plan requires a written statement for exception. 3) A provision from the prescribing physician indicating the drug for treatment would not be effective as the requested drug and/or would have adverse effects. 4) A provision stating additional supporting medical documentation may be required for approval. 5) A provision stating Molina Healthcare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement. 6) A provision stating that Molina Healthcare is waiting on a physician's statement in support of a tiering exception and must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing a determination on tiering exception. 7) A provision granting a tiering exception when it is determined that the drug for treatment of the enrollee's condition wuld not be as effective for the enrollee as the requested drug and/or would have adverse effects. A 2-tiered formulary must include a statement to the exception process indicating that Molina Healthcare only has 2 tiers, therefore a tiering exception is not necessary. Additionally, Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Molina Healthcare must revise its policies and procedures to include a provision stating: 1) An enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception. 2) The prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be efffective because all covered Part D drugs on any tier would not be as effective, clinical evidence would indicate the current drug regimen is ineffective or adversely affect effectiveness or patient compliance, prescription alternative(s) on formulary have been ineffective. 3) If Molina Healthcare makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. 4) Exception requests must not be kept open indefinitely when a physician does not submit a supporting statement. 5) If Molina Healthcare is waiting on a physician's statement in support of a formulary exception request, they must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. 5)Molina Healthcare must grant a formulary exception when it determines that one of the three factors discussed in Number 2 above have been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. 6) Molina Healthcare does not restrict the number of exception requests submitted per enrollee. Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina Healthcare must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If Molina Healthcare does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Refer to Section 30.2 (Exceptions) in Chapter 18 of the Prescription Drug Manual for guidance. The notice template in Appendix 11 in the same chapter, although intended for members, may be helpful in developing a notice for requesting information from prescribing physicians.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Molina Healthcare must develop and implement policies and procedures regarding Approval of Tiering and Non-formulary Exceptions Requests. Provisions in the policies must include: 1) Coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. 2) Enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. 3) All approved non-formulary drugs must be placed in existing cost-sharing tier(s). Molina Healthcare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina Healthcare must provide an analysis and explanation of why the universe submitted for WS-CD2_D contained no information. Provide CMS with a detailed corrective action plan to ensure that this element and universe population will be met consistently.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	The Plan needs to develop and submit phone scripts, enrollee notices informing members whether their complaints are grievances or coverage determinations, and the Notice of Inquiry Regarding an Excluded Drugs. Please explain how staff have been updated and trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe the minimum grievance data to be maintained and a record retention time frame of 10 years. Please refer to 42 CFR 423.456(g) and 42 CFR 423.505(e). The Policy must also state that the Plan will take prompt appropriate action including a full investigation of the complaint.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	The Plan needs to update Policy and Procedure No. MA-DGA-02 to describe how the Plan will train relevant staff. Please describe in detail how staff are trained and monitored.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Please update the policy to reflect that when the Plan decides to extend the response deadline it will notify beneficiaries the same day or as soon as possible. Please submit the Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Please submit your Notice of Plan¿s Decision Regarding a Grievance.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	On page 3 of the grievance Policy and Procedure, section 2 refers to expediting a grievance related to provider availability. There is no such provision for expedited grievances. The two examples under this paragraph are correct. Please eliminate the references to provider availability being a reason for an expedited grievance. Section 6 in this policy and procedure refers to notifying the beneficiary within 30 days. Expedited grievances must be responded to within 24 hours. Please correct the Plan response time frames for expedited grievances.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Molina Healthcare must revise its policies and procedures to include a provision for accepting written requests for standard redetermination of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination. Molina must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Molina must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Molina Healthcare must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Molina must provide CMS with documentation demonstrating its system for maintaining documentation of expedited redetermination requests in case files, accepting requests for expedited redeterminations, and documenting all oral requests in writing. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Molina Healthcare must revise its policies and procedures to include provisions stating: - Molina must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - Molina must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Molina must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Molina must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Molina Healthcare must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing. - indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification. - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Molina to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. - stating that Molina must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Molina does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Molina must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Molina Healthcare must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72-hour timeframe. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Molina has a system for expedited coverage determination reversals.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Molina Healthcare must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Molina must revise its policies and procedures to include a provision stating that if the issue is denial based on lack of medical necessity, then Molina must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina uses appropriate personnel to conduct redeterminations.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Molina must revise its policies and procedures to include a provision stating: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax to its designated fax number. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Molina must provide documentation to CMS demonstrating that Molina forwards untimely cases to the IRE.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision. - requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA-PD	Audit Findings	1/28/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Molina Healthcare must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. - include a provision requiring a notice to be sent informing the IRE of the effectuation. Molina must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its `Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, -a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, -a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and -a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CW -MM-AP-109 `Medicare Part D Prescription Drug Appeals': CPS 028 `Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process',CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW - MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process',CPS 028 `Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process',CPS 028 `Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled 'Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its 'Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process': CW -MM-AP-109 'Medicare Part D Prescription Drug Appeals': CPS 028 'Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 ' 'Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D - Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires¿, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW 'MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 Medicare Part D Coverage Determination and Exceptions Process,CPS 028 Medicare Part D Transition Process) to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D- Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled 'Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H0303	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its `Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027 `Medicare Part D Coverage Determination and Exceptions Process': CW MM-AP-109 `Medicare Part D Prescription Drug Appeals': CPS 028 `Medicare Part D Transition Process')to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process',CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027-'Medicare Part D-Coverage Determination and Exceptions Process', CPS 028 'Medicare Part D- Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process', CPS 028 `Medicare Part D Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination(CW MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must demonstrate to CMS that it is compliant with reconsideration decisions where UnitedHealth's determinations are fully or partially reversed. With regard to reconsideration cases for drug benefit (standard priority), UnitedHealth must effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 72 hours after the date it received notice reversing the determination.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0543	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	H contracts: UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its `Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, -a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, -a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and -a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CW -MM-AP-109 `Medicare Part D Prescription Drug Appeals': CPS 028 `Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 'Medicare Part D - Coverage Determination and Exceptions Process',CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 `Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0609	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its `Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, -a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, -a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and -a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CW -MM-AP-109 `Medicare Part D Prescription Drug Appeals': CPS 028 `Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 `Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment (CW -MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 `Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 `Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3749	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its 'Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027- 'Medicare Part D - Coverage Determination and Exceptions Process': CW 'MM-AP-109 'Medicare Part D Prescription Drug Appeals': CPS 028 'Medicare Part D-Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 ' 'Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW 'MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D-Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D- Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D- Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled 'Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H3805	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its `Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, -a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, -a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and -a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CW -MM-AP-109 `Medicare Part D Prescription Drug Appeals': CPS 028 `Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4590	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its 'Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027- 'Medicare Part D - Coverage Determination and Exceptions Process': CW 'MM-AP-109 'Medicare Part D Prescription Drug Appeals': CPS 028 'Medicare Part D- Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 'Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027-'Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D- Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D- Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5005	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its `Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, -a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, -a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and -a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Open

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CW -MM-AP-109 `Medicare Part D Prescription Drug Appeals': CPS 028 `Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, and -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its PDP plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': PDP001 `Standard and Expedited Appeals') to include a provision that indicates that the Prior Authorization System (PAS) tracks and maintains data required quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment (PDP001 `Standard and Expedited Appeals') to include the following provisions stating that: - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement. Specifically, the language in quotation marks must be added. Additionally, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 -`Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating: - that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. -that UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS -027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include provisions stating that: -the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if UnitedHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. -all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's health requires, based on the enrollee's health status, but not later than 30 days after UnitedHealth receiving the oral or written grievance. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	UnitedHealth must revise its policies and procedures regarding grievances related to quality of care (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include a provision stating that all grievances related to quality of care regardless of how the grievance is filed, must be responded to in writing. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (PDP001 Standard and Expedited Appeals) to include a provision stating that that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (PDP001, Standard and Expedited Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (PDP001 Standard and Expedited Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of a request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals of a request for payment (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	R5287	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring that a notice be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. UnitedHealth must provide CMS with a CMS-approved or accepted Notice of Inquiry Regarding an Excluded Drug.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth¿s marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its PDP plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Open

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': PDP001 `Standard and Expedited Appeals') to include a provision that indicates that the Prior Authorization System (PAS) tracks and maintains data required quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 'Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (PDP001 'Standard and Expedited Appeals') to include the following provisions stating that: - United Health must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement. Specifically, the language in quotation marks must be added. Additionally, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating: -that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. -that UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled 'Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include provisions stating that: -the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if UnitedHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. -all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's health requires, based on the enrollee's health status, but not later than 30 days after UnitedHealth receiving the oral or written grievance. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	UnitedHealth must revise its policies and procedures regarding grievances related to quality of care (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include a provision stating that all grievances related to quality of care regardless of how the grievance is filed, must be responded to in writing. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (PDP001 Standard and Expedited Appeals) to include a provision stating that that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (PDP001 'Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (PDP001, Standard and Expedited Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (PDP001 Standard and Expedited Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of a request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must demonstrate to CMS that it is compliant with reconsideration decisions where UnitedHealth's determination is fully or partially reversed. In cases where reconsideration for drug benefit (standard priority), UnitedHealth must provide notice to the IRE that it effectuated a reversal decision.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals of a request for payment (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5805	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring that a notice be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. UnitedHealth must provide CMS with a CMS-approved or accepted Notice of Inquiry Regarding an Excluded Drug.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth¿s marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its 'Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Open

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CW -MM-AP-109 `Medicare Part D Prescription Drug Appeals': CPS 028 `Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D - Transition Process') to include provisions stating that: - failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW -MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D - Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 `Medicare Part D Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: - medical information must be requested within 24 hours of the enrollee's initial request, and - UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must demonstrate to CMS that it is compliant with reconsideration decisions where UnitedHealth's determination is fully or partially reversed. In reconsideration cases for drug benefit (standard priority), UnitedHealth must effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 72 hours after the date it received notice reversing the determination. Additionally, UnitedHealth must provide notice to the IRE that it effectuated a reversal decision.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must demonstrate to CMS that it is compliant with reconsideration decisions where UnitedHealth's determination is fully or partially reversed. In reconsideration cases for drug benefit concerning payment (standard priority), UnitedHealth must effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 72 hours after the date it received notice reversing the determination.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5921	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must demonstrate to CMS that it is compliant with reconsideration decisions where UnitedHealth's determination is fully or partially reversed. In reconsideration cases for drug benefit (expedited priority), UnitedHealth must effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 24 hours after the date it received notice reversing the determination. UnitedHealth must provide notice to the IRE that it effectuated a reversal decision.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. UnitedHealth must provide CMS with a CMS-approved or accepted Notice of Inquiry Regarding an Excluded Drug.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its PDP plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Open

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements (CPS 027- 'Medicare Part D-Coverage Determination and Exceptions Process':PDP001 'Standard and Expedited Appeals') to include a provision that indicates that the Prior Authorization System (PAS) tracks and maintains data required quarterly reporting of all data requested in Reporting Requirements: Appeals.	Open

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (PDP001 `Standard and Expedited Appeals') to include the following provisions stating that: - United Health must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement. Specifically, the language in quotation marks must be added. Additionally, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027-'Medicare Part D-Coverage Determination and Exceptions Process' and PDP001 'Standard and Expedited Appeals') to include provisions stating: - that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. - That UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027- 'Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 'Standard and Expedited Appeals') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D -Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D- Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled 'Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations P and P, MA and Part D Grievances, Doc. #AG002) to include provisions stating that: -the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if UnitedHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. -all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's health requires, based on the enrollee's health status, but not later than 30 days after UnitedHealth receiving the oral or written grievance. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	UnitedHealth must revise its policies and procedures regarding grievances related to quality of care (Ovations P and P, MA and Part D Grievances, Doc. #AG002) to include a provision stating that all grievances related to quality of care regardless of how the grievance is filed, must be responded to in writing. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (PDP001 Standard and Expedited Appeals) to include a provision stating that that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (PDP001 'Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollees case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (PDP001 `Standard and Expedited Appeals') to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (PDP001, Standard and Expedited Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (PDP001 Standard and Expedited Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of a request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must demonstrate to CMS that it is compliant with reconsideration decisions where UnitedHealth's determination is fully or partially reversed. In reconsideration cases for drug benefit (standard priority), UnitedHealth must effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 72 hours after the date it received notice reversing the determination. Additionally, UnitedHealth must provide notice to the IRE that it effectuated a reversal decision.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals of a request for payment (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must demonstrate to CMS that it is compliant with reconsideration decisions where UnitedHealth's determination is fully or partially reversed. In reconsideration cases for drug benefit concerning payment (standard priority), UnitedHealth must effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 72 hours after the date it received notice reversing the determination. Additionally, UnitedHealth must provide notice to the IRE that it effectuated a reversal decision.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	S5820	Part D	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring that a notice be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must demonstrate to CMS that it is compliant with reconsideration decisions where UnitedHealth's determination is fully or partially reversed. In reconsideration cases for drug benefit (expedited priority), UnitedHealth must effectuate the IRE's reversal decision as expeditiously as the enrollee's health requires but no later than 24 hours after the date it received notice reversing the determination. Additionally, UnitedHealth must provide notice to the IRE that it effectuated a reversal decision.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealths marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its PDP plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: -a provision prohibiting payment by the person performing marketing to beneficiaries, -a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, -a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and -a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws(including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements (CPS 027-'Medicare Part D-Coverage Determination and Exceptions Process':PDP001 'Standard and Expedited Appeals')to include a provision that indicates that the Prior Authorization System (PAS) tracks and maintains data required quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating that: - failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (PDP001 `Standard and Expedited Appeals') to include the following provisions stating that: - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement. Specifically, the language in quotation marks must be added. Additionally, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027-'Medicare Part D-Coverage Determination and Exceptions Process' and PDP001 'Standard and Expedited Appeals') to include provisions stating: that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. - That UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 -'Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 'Standard and Expedited Appeals') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D- Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D-Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations P and P, MA and Part D Grievances, Doc. #AG002) to include provisions stating that: -the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if UnitedHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. -all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's health requires, based on the enrollee's health status, but not later than 30 days after UnitedHealth receiving the oral or written grievance. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	UnitedHealth must revise its policies and procedures regarding grievances related to quality of care (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include a provision stating that all grievances related to quality of care regardless of how the grievance is filed, must be responded to in writing. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (PDP001 Standard and Expedited Appeals) to include a provision stating that that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (PDP001 'Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (PDP001 'Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (PDP001, Standard and Expedited Appeals) and to include provisions stating that: - medical information must be requested within 24 hours of the enrollee's initial request, - UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (PDP001 Standard and Expedited Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of a request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals of a request for payment (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring that a notice be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its PDP plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': PDP001 `Standard and Expedited Appeals') to include a provision that indicates that the Prior Authorization System (PAS) tracks and maintains data required quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - 'Medicare Part D- Coverage Determination and Exceptions Process' and PDP001 'Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination 'as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (PDP001 'Standard and Expedited Appeals') to include the following provisions stating that: - United Health must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement. Specifically, the language in quotation marks must be added. Additionally, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 -`Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating: - that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. -that UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS -027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled 'Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include provisions stating that: -the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if UnitedHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. -all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's health requires, based on the enrollee's health status, but not later than 30 days after UnitedHealth receiving the oral or written grievance. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	UnitedHealth must revise its policies and procedures regarding grievances related to quality of care (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include a provision stating that all grievances related to quality of care regardless of how the grievance is filed, must be responded to in writing. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (PDP001 Standard and Expedited Appeals) to include a provision stating that that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (PDP001, Standard and Expedited Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (PDP001 Standard and Expedited Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of a request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals of a request for payment (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring that a notice be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its PDP plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process': PDP001 `Standard and Expedited Appeals') to include a provision that indicates that the Prior Authorization System (PAS) tracks and maintains data required quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating that: - failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment (PDP001 `Standard and Expedited Appeals') to include the following provisions stating that: - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement. Specifically, the language in quotation marks must be added. Additionally, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating: -that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. -that UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations PandP, MA and Part D Grievances, Doc. AG002) to include provisions stating that: -the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if UnitedHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. -all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's health requires, based on the enrollee¿s health status, but not later than 30 days after UnitedHealth receiving the oral or written grievance. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	UnitedHealth must revise its policies and procedures regarding grievances related to quality of care (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include a provision stating that all grievances related to quality of care regardless of how the grievance is filed, must be responded to in writing. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (PDP001 Standard and Expedited Appeals) to include a provision stating that that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (PDP001, Standard and Expedited Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE¿s request in a timely manner (PDP001 Standard and Expedited Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of a request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals of a request for payment (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring that a notice be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its PDP plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements (CPS 027- 'Medicare Part D - Coverage Determination and Exceptions Process': PDP001 'Standard and Expedited Appeals') to include a provision that indicates that the Prior Authorization System (PAS) tracks and maintains data required quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating that: - failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (PDP001 `Standard and Expedited Appeals') to include the following provisions stating that: - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement. Specifically, the language in quotation marks must be added. Additionally, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 ' 'Medicare Part D-Coverage Determination and Exceptions Process' and PDP001 'Standard and Expedited Appeals') to include provisions stating: - that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. - That UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 'Standard and Expedited Appeals') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include provisions stating that: -the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if UnitedHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. -all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's health requires, based on the enrollee's health status, but not later than 30 days after UnitedHealth receiving the oral or written grievance. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	UnitedHealth must revise its policies and procedures regarding grievances related to quality of care (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include a provision stating that all grievances related to quality of care regardless of how the grievance is filed, must be responded to in writing. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (PDP001 Standard and Expedited Appeals) to include a provision stating that that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (PDP001 'Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee¿s case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (PDP001 'Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (PDP001, Standard and Expedited Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (PDP001 Standard and Expedited Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of a request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals of a request for payment (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring that a notice be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its PDP plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process': PDP001 `Standard and Expedited Appeals') to include a provision that indicates that the Prior Authorization System (PAS) tracks and maintains data required quarterly reporting of all data requested in Reporting Requirements: Appeals.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating that: - failure to notify the enrollee within the timeframe `constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (PDP001 `Standard and Expedited Appeals') to include the following provisions stating that: - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement. Specifically, the language in quotation marks must be added. Additionally, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Open
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 -`Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include provisions stating: - that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. -that UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - `Medicare Part D - Coverage Determination and Exceptions Process' and PDP001 `Standard and Expedited Appeals') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policy and procedure regarding processing requests for exceptions to its tiered cost-sharing structure (CPS -027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	UnitedHealth must revise its policy and procedure regarding processing requests for exceptions for non-formulary drugs (CPS-027 `Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	UnitedHealth submitted to the audit team a policy and procedure entitled `Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include provisions stating that: -the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if UnitedHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. -all concerned parties must be notified of the grievance disposition as expeditiously as the enrollee's health requires, based on the enrollee's health status, but not later than 30 days after UnitedHealth receiving the oral or written grievance. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	UnitedHealth must revise its policies and procedures regarding grievances related to quality of care (Ovations PandP, MA and Part D Grievances, Doc. #AG002) to include a provision stating that all grievances related to quality of care regardless of how the grievance is filed, must be responded to in writing. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (PDP001 Standard and Expedited Appeals) to include a provision stating that that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (PDP001 `Standard and Expedited Appeals') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (PDP001, Standard and Expedited Appeals) and to include provisions stating that: -medical information must be requested within 24 hours of the enrollee's initial request, -UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and -failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (PDP001 Standard and Expedited Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of a request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals of a request for payment (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring a notice to be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA-PD	Audit Findings	1/28/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Standard and Expedited Appeals PDP 001) to include a provision requiring that a notice be sent informing the IRE of the effectuation. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Affinity Health Plan must resubmit all materials used to promote its Medicare Advantage plans to CMS (via HPMS) for review and approval. This includes materials utilized in the media (all newspaper and radio ads, presentations, posters, etc.). The plan must submit materials used for its television program. Affinity must submit a list of all marketing materials utilized in its corporate campaign to CMS for review. All materials that were not subject to the CMS marketing materials process, must be revised and the CMS marketing material number must be removed. That must be indicated in the list. Materials in other languages, must be submitted with its approved English version. All of this must be part of the Corrective Action Plan for this element.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Affinity Health plan must retrain its staff in all Medicare operational areas to ensure its staff has a comprehensive understanding of Medicare Advantage and Affinity's products. Affinity Health plan must revise all policies and procedures for its Medicare Advantage products paying particular attention to Sales, Marketing and Customer Service. Those areas were found to be the most deficient. Revised training manuals, tests for Sales staff must be submitted to the CMS Regional Office along with revised policies and procedures for review and approval.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	Submit plan to ensure the monitoring of delegated credentialing entities. Submit timetables when MAO wil be in compliance with regulations. Submit title of person who will monitor for compliance.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Affinity must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing in accordance with the Medicare Managed Care Manual, Chapter 6, Section 60.3. The reviewer requests that Affinity submit a plan of action that will include timetables and the name and title of the individual responsible for monitoring compliance. Revised policies and procedures explaining the process (signed by appropriate staff) must be submitted to the CMS Regional Office for review and approval.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Submit a plan to ensure the documented process for facility credentialing/recredentialing is followed. Submit title of person who will monitor for compliance.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 11 - Contracts	Adequate Compliance PlanThe MAO must have a formalized compliance plan that contains the requirements specified by CMS	CMS reviewed the Affinity Health Plan Compliance Plan and found that although it appears to include most of the required elements, the MAO's Compliance plan was not formalized and enforced as required by CMS. The Compliance plan must contain the following: 1. Written policies and procedures (included), 2. Designated compliance officer and committee officer (included), 3. Training and education (included), 4. Communication plan - It was not clear in the compliance plan that this was taking place. The reviewer was able to determine that there was not much communication taking place between the Compliance Officer and the depts. This needs to improve. The Compliance officer needs to establish a process of communication via email, memoranda and ongoing meetings. All departments must routinely report their progress to the Compliance Officer. 5. Disciplinary guidelines must be enforced, 6. Internal monitoring (must be included and enforced) 7. Development of corrective action inititiatives - corrective actions must be enforced. Affinity Health Plan was advised of this during the onsite. The MAO must outline actions taken to ensure compliance as required by CMS.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Affinity Health Plan must provide a CAP (Corrective Action Plan) that is consistent with the rules and regulations outlined in Chapter 13 of the Medicare Managed Care Manual, 10.1 and 20.2. Affinity must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms. All cases must be correctly categorized and consistent with documentation such as, call logs and customer service policies and procedures. All Policies and Procedures for Customer Service and Appeals and Grievance Departments must be revised to correctly define both the grievance and appeals process. They must be submitted to the Regional Office for review and approval.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	As a result of an internal audit of their Medicare claims files, prior to CMS's visit, Affinity Health Plan submitted on November 27, 2007 during the site visit a corrective Action Plan detailing the steps that they have taken to cure the deficiencies discovered during the review of their files. The deficiencies identified by Affinity Health Plan were confirmed by the CMS review on November 27, 2007. CMS reviewed Affinity Health Plan's Corrective Action Plan and accepts it as written. However, further action is required. Per Affinity's CAP: The actions that Affinity Health Plan has implemented to cure the identified deficiencies are as follows: ¿ The claims Department has developed a process and policies to ensure all claims are paid within thirty (30) days to include ¿ Re-train on the differences between a clean vs. a non-clean claim and the protocol to develop a non-clean claim ¿ Monitor and review reports specific to non-clean claims ¿ Implement new configurations for the Federal interest rate ¿ Interest is automatically calculated and paid in accordance with the CMS Requirement Ongoing Metrics ¿ The Claims Department Management staff will review a random sample of claims weekly to identify any claims that were not paid timely to determ ine 1. If it was clean or non-clean and 2. If the appropriate interest was paid Any concerns will be reported to Sr. Management Dates of Completion 1. Claims Management staff reviews the process daily via a report 2. New Configuration to support interest payments was moved to production on October 29, 2007. Based on Affinity's CAP, the reviewer is requesting that Affinity submit to CMS, a monthly report showing claims received starting with the month of December 2007, showing that claims being processed are meeting this requirement. The CAP will be released when the reports reflect the element has been met consistently.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	On November 30, 2007, while on site the CMS reviewer tested the newly implemented data system AMISYS to determine whether interest was paid on claims over thirty (30) days. The reviewer selected a sample of nine (9) additional claims for services received after the sample period. AMISYS (which is the claims processing system) was able to calculate the correct Medicare interest rates for each claims over thirty (30)days. Therefore, no further action is necessary for this element.	Closed

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Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	Affinity Health Plan must ensure that it pays or denies all non-contracted claims that do not meet the definition of "clean claim" within sixty (60) calendar days of receipt. All paper claims received must be date stamped or Julian dated. Affinity Health Plan must establish and maintain effective oversight controls over the claims processing unit. Affinity Health Plan must submit Policies and Procedures which describes the type of oversight activities that it will implement over its claims processing unit. Affinity Health Plan must submit to the Regional Office, monthly monitoring reports, beginning with December 2007 showing timeliness. The element will be released when CMS finds that Affinity Health Plan has consistently met the requirement.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Affinity Health Plan must provide a CAP (Corrective Action Plan) that is consistent with the rules and regulations outlined in Chapter 13 of the Medicare Managed Care Manual, 40.1 and 40.3. When a beneficiary makes a request for services, Affinity must notify the beneficiary of its decision as expeditiously as the health condition of the beneficiary requires, however, no later than 14 days after Affinity receives such request. Affinity must notify the beneficiary in writing using the model Notice of Denial of Medical Coverage, or a Regional Office approved modification of the notice. Affinity must closely monitor this area to ensure that notices are issued and appeal rights are provided to its members.	Closed
Affinity Health Plan	1-718-794-5731	H5991	MA	Audit Findings	1/24/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	Affinity Health Plan must provide a CAP (Corrective Action Plan) that is consistent with the rules and regulations outlined in Chapter 13 of the Medicare Managed Care Manual, 30 and 70. The CAP must be inclusive of the following: The ability to adequately distinguish between organization determinations and reconsiderations. All information on payments and Medicare coverage. Discontinuation of services and/or reduction. Timely services and notices. Established procedures for timely organization determinations. Acknowledgement of the appeals process for unfavorable decisions. Clarify who may request a standard reconsideration, including instructions and timeframes. This should also include information on the failure to adhere to timeframes. Extensions, opportunities to submit evidence and withdrawals. In addition, Affinity must show proof of staff training and ability to comply with the above mentioned.	Closed

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Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.	WHP must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. As mentioned above, WHP has already submitted its notice to the CMS marketing review process for approval. WHP submitted to the audit team a "Notice of Case Status" template notice that was reviewed and approved through the CMS marketing material review process in December 2007 (post-audit period). Therefore, no corrective action is required for this deficiency. WHP must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice 'Request for Additional Information'). If WHP does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WHP has indicated that it has already submitted the "Request for Reconsideration" notice template for CMS approval through the normal marketing review submission process. WHP must provide CMS with evidence that it has received CMS approval for this template. WHP must conduct training of appropriate staff on the use of these notice templates and submit documentation to CMS that details the nature of this training including, the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	WHP must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to include a requirement that any person directly employed or contracted to market on behalf of WHP provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: "The person that is discussing plan options with you is either employed by or contracted with Windsor Health Plan, Inc. The person may be compensated based on your enrollment in a plan." WHP must also include this requirement in its agent/broker training documents. WHP must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WHP must monitor its marketing representatives to confirm they are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and provide CMS with documentation demonstrating that it is doing so. WHP must review the state licenses and Broker Agent Agreements of all its direct employees and contracted brokers to ensure they are valid for the state(s) in which the marketing representatives are actually performing marketing activities. WHP must provide CMS with documentation that indicates it has conducted this review, and made corrective actions as necessary.	Closed

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Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	WHP must revise its policies and procedures for providing notification of formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage (WHP-PHARM-005, WHP-PHARM-006, WHP-PHARM-013, and WHP-PHARM-032) to include the following: - A provision with a description of the procedures for providing a notice of "maintenance" formulary changes to CMS, in accordance with CMS requirements. - A provision with a description of the procedures for providing a notice of "other" formulary changes to CMS, in accordance with CMS requirements. - A provision with a description of the procedures for providing retrospective notice to CMS if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. WHP must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WHP must also provide a retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is deemed unsafe by the FDA or removed from the market by the manufacturer. Although WHP did not have SPAPs in its coverage area during the audit period, it must provide this notice to SPAPs in the future if SPAPs exist in its coverage area. WHP must conduct training of appropriate staff on the use of this notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	WHP provided the audit team with revised network long-term care pharmacy contracts for sample cases #2 and #5 that showed that those two contracts were compliant with CMS requirements as of 11/5/2007 (post audit period). WHP must amend its other network long-term care pharmacy contracts to include the CMS-specified performance and service criteria for long-term care pharmacies. WHP must provide a copy of the language in the contract and inform CMS when all amendments are issued and in effect.	Closed

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Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	WHP must revise its policies and procedures regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception (WHP-PHARM-028 and WHP-PHARM-038) to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. WHP must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WHP submitted to the audit team revised copies of its network pharmacy contract templates dated post-audit period. The audit team has reviewed these templates and found them to be compliant with the requirement to include a provision requiring pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception. Therefore, no further corrective action is required for the second deficiency listed for this element. WHP must demonstrate that its network pharmacies are posting or distributing the "Medicare Prescription Drug Coverage and Your Rights" notice. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WHP must revise its policy and procedure regarding enrollee notification of coverage determinations concerning drug benefit (WHP-PHARM-004) to clearly state that failure to notify the enrollee of its determination within the required timeframe "constitutes an adverse coverage determination." WHP must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WHP must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (WHP-PHARM-004) to clearly state that failure to notify the enrollee of its determination within the required timeframe "constitutes an adverse coverage determination." WHP must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WHP must notify enrollees of standard coverage determinations concerning payment within the CMS-approved timeframe and provide documentation of this to CMS.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WHP must revise its policy and procedure regarding decisions to accept or deny requests for expedited coverage determinations (WHP-PHARM-004) to include a discussion of the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WHP must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WHP must revise its policy and procedure regarding enrollee notification following a decision on an expedited coverage determination (WHP-PHARM-004) to include a provision stating that if a decision is adverse and WHP first notifies the enrollee of the determination orally, WHP must mail written confirmation to the enrollee within 3 calendar days of the oral notification. WHP must revise its policy and procedure regarding enrollee notification following decision on an expedited coverage determination (WHP-PHARM-004) to clearly state that failure to notify the enrollee of its determination within the required timeframe "constitutes an adverse coverage determination." WHP must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WHP must notify enrollees of its expedited coverage determination decisions within a timeframe that is compliant with CMS requirements and provide documentation of this to CMS.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WHP must revise its policy and procedure regarding enrollee notification following a decision on an expedited coverage determination (WHP-PHARM-004) to include a provision stating that if oral notice is provided for an adverse decision on an expedited coverage determination, the notice must (1) state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, (2) provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf and (3) provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WHP must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WHP must inform members whether their complaint is subject to grievance or coverage determination procedures to demonstrate compliance with CMS requirements.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WHP must revise its policy and procedure regarding enrollee notification of grievance disposition (WHP-GA-013) to include the specification that notification must occur "as expeditiously as the enrollee's case requires, based on the enrollee's health status." In addition, the policy and procedure must address timeliness of oral responses to grievances as well as written responses. WHP must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	WHP must revise its policy and procedure regarding timely response to expedited grievances (WHP-GA-013) to include a provision stating that WHP must respond within 24 hours to the enrollee's expedited grievance if the complaint involves a refusal by WHP to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased the drug that is in dispute. WHP must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WHP must revise its policy and procedure regarding timely notification and effectuation of standard redeterminations concerning drug benefits (WHP-GA-012) to include a provision stating that WHP must inform the enrollee within 24 hours when the case is forwarded to the IRE because WHP did not notify the enrollee within the required timeframe. WHP must conduct training of its staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WHP must provide CMS with documentation demonstrating that it is using a CMS-approved notice, Request for Reconsideration, for denied redeterminations concerning drug benefit.	Closed

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Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WHP must revise its policy and procedure regarding timely notification and effectuation of standard redeterminations concerning payment (WHP-GA-012) to include a provision stating that WHP must inform the enrollee within 24 hours when the case is forwarded to the IRE because WHP did not notify the enrollee within the required timeframe. WHP must conduct training of its staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA-PD	Audit Findings	1/23/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WHP must revise its policy and procedure regarding enrollee notification following decision on expedited redetermination (WHP-GA-012) to include a provision stating that WHP must inform the enrollee within 24 hours when the case is forwarded to the IRE because WHP did not notify the enrollee within the required timeframe. WHP must conduct training of its staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WHP must also provide CMS with documentation demonstrating that when it needs to request additional medical information, it makes the request within 24 hours of receiving the initial request for an expedited redetermination.	Closed
Humana Inc.	1-502-580-3683	H1036	MA	Ad-Hoc Compliance Event	1/17/2008	Open	Chapter 99 - Ad-Hoc Compliance Event			Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	Describe the actions Health Plan of San Mateo is taking to ensure its delegated credentialing entities credential/recredential contracted providers in accordance with CMS requirements. This must include policy and procedure revisions for the delegated entities. The corrective action must include delegation oversight audits of credentialing files to ensure compliance.	Closed

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Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 05 - Quality Assurance	Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).	Document the CCIP on the required reporting template. In particular, provide clarity and detail in the following areas: defining the targeted population, providing specific criteria for inclusion, describing how the conditions are relevant to the plan's own population, monitoring elements, and quantitative outcome measures.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Describe the actions Health Plan of San Mateo is taking to ensure it and its delegated credentialing entities credential/recredential contracted providers in accordance with CMS requirements. This must include policy and procedure revisions for the health plan as well as its delegated entities. The corrective action must include internal health plan audits as well delegation oversight audits of credentialing files to ensure compliance.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Develop a process to ensure that your delegated entity that processes CareAdvantage grievances from its patients maintains a copy of the member's written grievance. Or, if the grievance is filed orally, that internal systems notes are maintained and available for review.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Develop a process to ensure that grievances, both those processed by the health plan as well as entities delegated for grievance processing, are processed timely and all documentation is kept in the file.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Revise grievance resolution notices to ensure they meet CMS requirements and submit them for review through HPMS. Develop a process to ensure that all relevant documentation of the grievance is maintained in the file.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	Develop a process to ensure that all members who file grievance receive a grievance resolution notice.	Closed

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Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	The health plan must revise its policies and procedures to ensure that denial notices sent to members are maintained in the file and available for review. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. The health plan should conduct an internal audit each month of CareAdvantage denied claims. This audit should evaluate whether claims are being properly denied, processed timely, and whether proper denial language is included in the notices. Please submit a summary report once a quarter to the regional office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit. Upon receipt of the quarterly audit findings, if it is determined that HPSM is in compliance for three consecutive months, CMS will permit quarterly internal auditing. If, upon review of the quarterly audits, it is determined that HPSM has fallen out of compliance, HPSM must revert to the monthly audit schedule until the health plan can demonstrate three consecutive months of compliance.)	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	Develop a process to ensure that delegated entities are aware of and are implementing Medicare payment amounts when processing non-contracted CareAdvantage claims.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	HPSM must revise its oversight policies and procedures to ensure that claims processed by delegated entities are processed timely. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. HPSM must establish and maintain effective oversight controls over its delegated entities to ensure that CareAdvantage claims are processed according to CMS requirements for timeliness. HPMS must submit a policy and procedure that describes the types of oversight activities it will implement over its delegated entities. HPSM should conduct regularly scheduled audits of CareAdvantage clean claims processed by its delegated entities that have claims processing responsibilities for CareAdvantage claims. This audit should evaluate whether claims are being processed timely. Please submit a summary report once every six months to the regional office of your audit findings until further notice. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Develop a process to ensure that HPSM and its entities delegated for claims processing responsibilities of CareAdvantage claims pay interest at the correct amount on clean claims paid more than 30 days after receipt.	Closed

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Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	HPSM must revise its policies and procedures to ensure that non-contracted, non-clean claims are processed timely. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. HPSM should conduct an internal audit on a regular basis of CareAdvantage non-contracted, non-clean claims. This audit should evaluate whether claims are being properly and timely developed and processed timely. Please submit a summary report once every six months to the regional office of your audit findings until further notice. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Develop a process to ensure that for both HPSM as well as delegated entities, copies of the denial notice for denied claims is maintained in the file and available for review. Revise the language describing the denied benefits in denial notices so that it is clearer and more meaningful to the member. Ensure that it does not contain medical or clinical jargon, and that the member will know what services are being denied (and hence what services they may appeal) based on the description in the letter. You may want to consult or use the ICE denial reason matrix, approved by CMS. For your delegated entities, develop a process to ensure that denial notices are sent to members when the member has financial liability for the claim.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Health Plan of San Mateo must submit a new universe for WS-OP1 (Standard Pre-Service Denials) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP1 universe from the health plan's delegated entity.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Health Plan of San Mateo must submit a new universe for WS-OP1 (Standard Pre-Service Denials) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP1 universe from the health plan's delegated entity.	Closed

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Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Health Plan of San Mateo must submit a new universe for WS-OP2 (Requests for Expedited Organization Determinations) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP2 universe from the health plan's delegated entity.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Health Plan of San Mateo must submit a new universe for WS-OP2 (Requests for Expedited Organization Determinations) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP2 universe from the health plan's delegated entity.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	Health Plan of San Mateo must submit a new universe for WS-OP2 (Requests for Expedited Organization Determinations) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP2 universe from the health plan's delegated entity.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	Describe actions Health Plan of San Mateo is taking to ensure that it is using the CMS required DENC when a beneficiary appeals to the Quality Improvement Organization (QIO)for Terminations of Services with SNF, HHA, or CORF Providers. Corrective action must include internal health plan audits to ensure compliance.	Closed

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Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	Develop a process to ensure that appeals are processed according to CMS requirements and that copies of all relevant notices are maintained in the files and available for review. Revise your policy and procedure to indicate that when appeals are filed by a party other than the member, HPSM makes a documented effort to obtain the appropriate documentation (Appointment of Representative, waiver of payment liability, durable Power of Attorney, etc.) Include in the revision the correct process to follow according to CMS requirements when the appropriate documentation is not obtained from the third party.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA	Audit Findings	1/11/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	Revise your policy and procedure to indicate the correct procedure to follow when you do not obtain AOR documentation (or other representative documentation) with the appeals timeframe. Train appropriate staff on this revised process and provide documentation of the training in the Corrective Action Plan.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	HPSM must update it's policies and procedures to include: (1) A provision for arranging with their network pharmacies to post or distribute the Medicare Prescription Drug Coverage and Your Rights pharmacy notice instructing enrollees to contact their plan to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist. (2) A provision for the Health Plan (or through their PBM) to arrange with its network pharmacies to post or distribute the Medicare Prescription Drug Coverage and Your Rights notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices (3) A provision detailing how Part D Sponsors network pharmacies meet the requirement for posting or distributing notices. Although, the MedImpact's policy and procedure (# 310-PD-001) with an unknown effective date addresses specific requirements for contracted pharmacies, the CMS requirements discussed were not delineated. HPSM may want to work with MedImpact to include in both their template contract and audit check list specific language regarding the Medicare documentation requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	HPSM must revise its policies and procedures to include a definition of coverage determination that is in accordance with 423.566(b)(1-5) .	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HPSM must correct its internal coding to ensure that standard coverage determination cases are correctly classified. HPSM must also resubmit a corrected universe for Standard Coverage Determinations for Benefits (worksheet WSCD1_D) for the same review period as part of its corrective action plan.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	HPSM must revise its policies and procedures to state that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party).	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HPSM must revise its policies and procedures to (A) include a telephone number for oral requests, and (B) state that oral requests must be documented in writing and that the documentation must be maintained in case file.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HPSM must revise its policies and procedures to include provisions stating (1) if decision is adverse and the sponsor first notifies the enrollee of the determination orally, the sponsor must mail written confirmation within 3 calendar days of the oral notification. (2) that failure to notify the enrollee within the timeframe constitutes adverse determination and sponsor must forward request to IRE within 24 hours of the expiration of the adjudication timeframe, and (3) that sponsor must inform enrollee within 24 hours when the case is forwarded to IRE.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	HPSM must revise its policies and procedures to include (1) a provision stating that if decision is adverse, sponsor must use Notice of Denial of Medicare Prescription Drug Coverage, and (2) a provision stating that if oral notice is provided for adverse decision, the notice must satisfy the following requirements: a. States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. b. Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. c. Provides a description of both the standard and expedited redetermination processes and timeframes, including the conditions for obtaining an expedited redetermination.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	HPSM must (A) develop and submit for approval a notice that is consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug, and (B) describe the steps it is taking to ensure that cases are correctly categorized as grievances, coverage determinations, or both.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	HPSM must (A) revise its policies and procedures to include a provision for training relevant staff on grievance polices and procedures (B) conduct grievance training for its staff and submit documentation of training to CMS.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	HPSM must (A) revise its policies and procedures to include the provision stating that members will be immediately notified in writing when the plan extends the deadline (B) develop and submit for approval a notice consistent with CMS-issued model notice, Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance, and (C) explain to CMS what actions it will take to ensure that it is meeting the timeliness standards for grievances in accordance with CMS policy and regulations. The corrective action must include a detailed description of HPSM's internal monitoring activities to ensure compliance for this element.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	HPSM must (A) revise its policies and procedures to include a provision stating that oral grievances will be responded to in writing if the member requests a written response, and (B) revise its Notice of Plan's Decision Regarding a Grievance to include days and hours of operation and submit to CMS for approval.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	HPSM must revise its Notice of Plan's Decision Regarding a Quality of Care Grievance to correct the language regarding appeals and to include the plan days and hours of operation, and submit it to CMS for approval.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	HPSM must revise its policies and procedures to include the provision stating that the plan must provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	HPSM must revise its policies and procedures to include the telephone number for oral requests and/or a fax number to facilitate receipt of expedited requests.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HPSM must revise its policies and procedures to include the provision stating that any additional medical information that the Part D sponsor requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	HPSM must develop and submit for approval a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance. On December 7, 2007, HPSM submitted a Notice of Right to an Expedited Grievance. No further corrective action is required	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HPSM must develop and submit for approval a notice consistent with CMS-issued model notice, Request for Reconsideration. On December 7, 2007, HPSM submitted a Request for Reconsideration notice. No further corrective action is required.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HPSM must develop and submit for approval a notice consistent with CMS-issued model notice, Request for Reconsideration. On December 7, 2007, HPSM submitted a Request for Reconsideration notice. No further corrective action is required	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HPSM must (A) revise its policies and procedures to include the following (1) a provision indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, (2) a provision stating that medical information must be requested within 24 hours of the enrollee's initial request, (3) a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and (4) a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and (B) develop and submit for approval notices consistent with CMS-issued model notices, Notice of Right to an Expedited Grievance and Request for Reconsideration. On December 7, 2007, HPSM submitted a Notice of Right to an Expedited Grievance and Request for Reconsideration notice.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	HPSM must revise its policies and procedures to include the provision stating that a physician who was not involved in making the coverage determination will conduct the redetermination.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	HPSM must (A) revise its policies and procedures to include (1) a provision stating that case files must be sent to the IRE within 24 hours for expedited requests, and (2) a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number, and (B) explain to CMS what actions it will take to ensure that it is meeting the timeliness standards for transferring case file to the IRE in accordance with CMS requirements. The corrective action must include a detailed description of HPSM's internal monitoring activities to ensure compliance for this element.	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HPSM must develop and submit for approval a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D IRE. On December 7, 2007, HPSM submitted a Notice of Effectuation to Part D IRE. No further corrective action is required	Closed
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HPSM must (A) revise its policies and procedures to include: (1) a provision stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision, (2) a provision stating that payment must be made no later than 30 days from the date it receives notice reversing the decision, and (3) a provision requiring a notice to be sent informing the IRE of the effectuation, and (B) develop and submit for approval a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D IRE. On December 7, 2007, HPSM submitted a Notice of Effectuation to Part D IRE.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Health Plan of San Mateo	1-650-616-2151	H5428	MA-PD	Audit Findings	1/11/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HPSM must develop and submit for approval a notice consistent with CMS-issued model notice, Notice of Effectuation to Part D IRE. On December 7, 2007, HPSM submitted a Notice of Effectuation to Part D IRE. No further corrective action is required.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	S5555	Part D	Audit Findings	1/9/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	MAO must provide policies and procedures to address maintenance of sales representative files to ensure contents are consistent throughout, contain all necessary documentation and are updated and monitored regularly. Plan must demonstrate via policy and procedures how it will address sales representative's who have provisional Commonwealth licenses and what will happen to these individuals after this period expires. Plan must revise all contracts with individuals employed/or contracted to sale product to include all regulatory requirements. Submit to CMS within the first quarter of 2008, timelines as to when the plan expects to have all contracts revised to comply with CMS requirements.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	S5555	Part D	Audit Findings	1/9/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	MCS must revise its policy and procedures to ensure that it notifies all enrollees of their decision as expeditiously as the enrollee's health requires, but no later than 30 days after the date the organization receives the grievance, unless extended by the plan for up to 14 calendar days. The revised policy and procedures must also state that the plan must respond to a grievance within 24 hours if: (1) the grievance involves a refusal by the Part D plan sponsor to grant an enrollee's request for an expedited coverage determination or expedited re-determination, and (2) the enrollee has not yet purchased or received the drug that is in dispute.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	S5555	Part D	Audit Findings	1/9/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Plan must ensure that all grievances are processed according to 42CFR section 423.564(e(3)(i-ii) and according to chapter 18 Part D enrollee Grievances, Coverage Determinations and Appeals manual. The Plan must audit this area on a regular basis to ensure that all correspondence contains appropriate language to address members concerns.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA-PD	Audit Findings	1/9/2008	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	MAO must provide policies and procedures to address maintenance of sales representive files to ensure contents are consistent throughout, contain all necessary documentation and are updated and monitored regularly. Plan must demonstrate via policy and procedures how it will address sales representative's who have provisional Commonwealth licenses and what will happen to these individuals after this period expires. Policies and procedures need to be implemented to address handling of marketing allegation by including evidence of an investigation in accordance to CMS regulations. Feedback and disciplinary action need to be addressed at the compliance level and documented within the sales representative file. Performance data needs to be gathered regularly and documented in the sales representative file as well.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA-PD	Audit Findings	1/9/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Plan must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Plan should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. Pharmacy Department must secure those materials approved for the stand-alone plans (S5555) are not issue to enrollees under the H4006. Plan must keep these products separate to avoid confusing members. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. In addition, CMS is requesting that a summary report be submitted once a quarter to the Regional Office of its monthly findings until further notice. This report is due to the Regional Office within 15 days of the close of the quarter. The summary report should include: title of the auditor(s), the audit methodology and the result of the audit.	Open
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA-PD	Audit Findings	1/9/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	30% of the cases were misclassified as grievances when they should have been processed as a coverage determination. In addition, it was noted that the Pharmacy Department was using CMS approved grievance notification materials approved for the Part D stand alone plan (S5555) to address MA-PDP grievances under the H4006 product.	Open
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA-PD	Audit Findings	1/9/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	MCS must submit a new sample that contains all standard grievances received during the audit period (including those still pending). Although the Part D sponsor may use another term to describe it, please note that the term "grievance" is meant to include any complaint or dispute, other than that that involves coverage determination, expressing dissatisfaction with any aspect of the operation, activities, or behavior of a Part D sponsor, regardless of whether remedial action is requested. This includes issues received verbally (telephone) as well as in writing.	Open

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Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA-PD	Audit Findings	1/9/2008	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	MCS must submit a new sample that contains all standard grievances received during the audit period (including those still pending). Although the Part D sponsor may use another term to describe it, please note that the term "grievance" is meant to include any complaint or dispute, other than that that involves coverage determination, expressing dissatisfaction with any aspect of the operation, activities, or behavior of a Part D sponsor, regardless of whether remedial action is requested. This includes issues received verbally (telephone) as well as in writing.	Open
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.	The Plan had identified this problem back in March 2007, and immediately implemented a correction action plan. The MAO began issuing disenrollment noticies to members disenrolled through sources other than the MAO in March, 2007. The Plan must closely monitor this process to ensure that letters are issued in a timely manner in accordance to 42 CFR 422.66(b)(3) and Medicare Managed Care Manual Chapter 2, Section 50.1.4.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Notice Content) - The MAO sends the disenrollment notice to the member in a format specified by CMS, providing the correct effective date of disenrollment.	The MAO must ensure that this element is met per 42 CFR 422.66(b)(3)(ii)-(iii) and the Medicare Managed Care Manual, Chapter 2, Section 50.1.4.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	The MAO must ensure that it correctly notifies beneficiaries of enrollment denials in accordance to timeframes specified at 42 CFR 422.60(e)(3) and Medicare Managed Care Manual, Chapter 2, Section 40.2.3.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	MCS must revise the final notice of Enrollment Rejection letter. They must describe CMS' acceptance or rejection of enrollment in accordance with 42 CFR 422.60(e)(3) and Medicare Managed Care Manual, Chapter 2, Section 40.4.2. The Plan must submit a revised letter to the Regional Office for review and approval no later then 10 days after receipt of this report.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Plan must demonstrate recurrent use of attestation for all non-English pieces of submitted marketing materials per CMS Managed Care Marketing Guidelines. Plan must monitor File and Use materials to ensure accuracy of said materials prior to printing and to ensure that they meet CMS Marketing Guidelines. Plan must ensure materials are reviewed for accuracy prior to submitting to CMS. Plan must have process in place for receiving recommendations and or comments from CMS reviewer and incorporate said changes into materials prior to re-submission. Plan must establish a process to ensure CMS that all future Annual Notification materials will meet CMS mailing timelines.	Closed

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Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	MAO must provide policies and procedures to address maintenance of sales representive files to ensure contents are consistent throughout, contain all necessary documentation and are updated and monitored regularly. Plan must demonstrate via policy and procedures how it will address sales representative's who have provisional Commonwealth licenses and what will happen to these individuals after this period expires. Policies and procedures need to be implemented to address handling of marketing allegation by including evidence of an investigation in accordance to CMS regulations. Feedback and disciplinary action need to be addressed at the compliance level and documented within the sales representative file. Performance data needs to be gathered regularly and documented in the sales representative file as well.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.	Information was provided to the MAO during the onsite review reflecting the review of the HSD tables and areas identified by CMS that required intervention by the MAO to pursue a contract with providers in the identified areas. The MAO will contact providers and provide narratives of success with contracting or declination of contract with narrative explanations. The MAO will submit monthly reports to the Regional Office for six months with a work plan for determining network capacity, network outreach and successful contract with providers.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 04 - Benefits and Beneficiary Protections	Services Provided with Cultural Competence - The MAO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds.	MCS will develop a corrective action plan to address the issue identified. MCS will develop a policy and procedure, provider manual, and develop a hearing impaired policy, implement a TTY/TDD line, and develop a policy on Interpreter services and will forward policies to Regional Office for review. MCS will post all revisions to provider manual on MCS physician intranet. MCS will train all employees on policies and provide evidence of training to CMS Regional Office.	Closed

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Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 04 - Benefits and Beneficiary Protections	Confidentiality of Member Information - The MAO implements procedures to ensure the confidentiality of member medical records and other member information.	MCS will develop confidentiality policy and procedure incorporating required elements and identifies persons necessary to be in compliance with policy, i.e. all committee members, external providers who have access to member information, applicable staff, and delegated vendors. MCS will forward policy to Regional Office for review. MCS will have all employees, committee members, delegated affiliates sign confidentiality statements. MCS will develop policy statement determining length of time that signed statement is valid, i.e. staff members length of employment, committee members 1 year, UM providers 2 years delegated vendors etc. MCS will retain copy of signed statements. Committee members will sign statements per developed policy. Delegated affiliates will sign statements per developed policy. MCS will submit copies of signed statements to CMS Regional Office for review. Information to be submitted to the Regional Office by March 2008.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 04 - Benefits and Beneficiary Protections	Oversight of Delegated Entities with Chapter 4 Responsibilities - If any of the activities or responsibilities for the above elements in Chapter 4 are delegated to other parties, the MAO must oversee them per CMS standards.	The MAO organization will develop an audit tool that will assist them in performing oversight of the delegated entity. Audit tool will encompass the following: review of contract, credentialing review of initial credentialing files and recredentialing files following CMS's guidelines. Facility credentialing should following CMS's guidelines, on review of quality of care issues, utilization issues and concerns, delegated vendors policies and procedures, delegated organizations board meeting minutes, noting information applicable to contract with MCS, application of Medicare coverage guidelines and member complaints, grievances, appeals. MCS will forward a copy of audit tool to the CMS Regional office by March 1, 2008.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	MCS must incorporate the following elements in their QA program, work plan, narrative and evaluation. Customer service, appeals and grievances, credentialing including facility credentialing, provider relations, claims, sales and marketing. This documentation should also include oversight of delegated entities, member input etc., and incorporation of CCIP, HEDIS, CAHPS and individual studies designated by the plan. This documentation must then be submitted for review, discussion and approval by the Governing Board on an annual basis in the 1st quarter of the year in order for the plan to be implemented. MCS must submit to the Regional Office for review a revised 2007 QA Workplan, 2006 evaluations, 2007 QA Description that incorporates all required elements and individual departments quality improvement activities and this document to reflect oversight of delegated entities and member input into the quality program. MCS will submit to the Regional Office the 2008 QA workplan, 2007 evaluation and 2008 QA Description. MCS must submit copy of signed governing board minutes that document review of the Quality Improvement Program, yearly evaluation and annual workplan. MCS will submit governing board meeting minutes for 2007 and 2008 which reflect governing board approval.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	The MAO will follow up on calendar year 2006 and request that issues identified with policies, and quality improvement and utilization management be addressed with a corrective action plan. The MAO will develop a audit check list which incorporates the following items. Credentialing: Perform a credentialing audit of delegated files, include both initial credentialing and recredentialing. Retain results of audit and attach to yearly review file. Review Member complaints, grievances and appeals. Review QI activity Review QI studies Review Policy and Procedure update Review of UM data Review of credentialing committee minutes Review of credentialing files with list attached to final report. Review of governing board activities pertaining to contract with MCS. The MAO will perform an in depth review of delegated vendors within first six (6)months of 2008. The MAO will forward results of oversight of delegated vendor to Regional Office for review. The MAO will issue a deficiency report to delegated vendor with request for corrective action plan for issues identified for calender year 2007.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 05 - Quality Assurance	Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.	Revise the 2006 Quality Improvement Project so that reported data for each measurement period follows HEDIS specifications for the defined quality indicator. HEDIS sampling methodology rather than a reduced sample size is required so that the project's impact on the target population can be evaluated. Implement interventions specifically focused on improving the QI project's quality indicator. Submit the revised report to the evaluation entity, MAQRO.	Closed

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Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 06 - Provider Relations	Participation and Termination Procedures - The MAO must have written policies and procedures and a process for rules of physician participation and adverse participation decisions.	MCS must actively recruit community based participating physicians to be members of the credentialing committee and a distinct group of physicians for the appeals committee who are not employees of the MAO. The committee participants should actively participate in the Peer Review Process. Documentation in committee minutes should reflect participation of all members of the credentialing committee. Committee minutes documentation to follow industry standards, quorum, chairperson, list of providers to be credentialed attached, confidentiality statements signed by all committee members, open items addressed at the next meeting, improved description of quality review for recredentialing. Documentation should also include minutes of review and approval/disapproval of delegated providers. MCS must submit revised policies to the Regional Office that describe the composition of the credentialing committee, the appeals committee etc., and the number of committee members who are external to the MAO. MCS will submit to the Regional Office a list of external providers who have agreed to be members of the credentialing committee along with signed statements of confidentiality. This list is to be submitted with the minutes of the credentialing committee for six (6) committee meetings beginning the first quarter of 2008.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 06 - Provider Relations	Consultation with Physicians and Subcontracted Physician Groups - The MAO must establish a formal mechanism to consult with the physicians and subcontracted groups that have agreed to provide services regarding the organization's: medical policy, quality assurance programs, and medical management procedures.	MCS must actively recruit community based participating physicians to be members of the various committees who are not employees of the MAO. The committee participants should actively participate in the Peer Review Process, medical policy, quality assurance program and medical management committee. Documentation in various committee minutes should reflect participation of all members of the committee. Committee minutes documentation to follow industry standards, quorum, chairperson, problem identified, corrective action, resolution, confidentiality statements signed by all committee members, open items addressed at the next meeting, improved description of activities of each committee. MCS must submit revised policies to the Regional Office that describe the composition of the various committees, the appeals committee etc., and the number of committee members who are external to the MAO. MCS will submit to the Regional Office a list of external providers who have agreed to be members of the various committees along with signed statements of confidentiality.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	MCS will develop a corrective action plan that depict the oversight of the credentialing department, oversight of delegated entities for credentialing and recredentialing, development of formal credentialing requirements for facility credentialing. MCS will submit CAP to the Regional Office for review. MCS will improve committee minutes by following format listed below. MCS will attach list of providers who are to be approved or disapproved to all committee minutes. MCS will identify providers with unique ID number in all credentialing committee minutes. This unique number will also be included on all credentialing files. MCS will submit credentialing committee minutes for six (6) committee meetings starting with December 2007. MCS will develop a self audit tool to monitor credentialing files. Random sample of 10-20 files monthly for compliance with regulatory requirements. MCS will submit results of 2 quarters of results of internal audit of credentialing files.	Closed

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Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 06 - Provider Relations	Process for Consultation with Health Care Professionals Regarding CredentialingThe MAO must have a process for health care professionals' input in the credentialing process.	MCS must actively recruit participating providers to be members of the credentialing committee who are not employees of MCS. The committee participants need to actively participate in the Peer Review Process. Documentation in committee minutes needs to reflect participation of all members of the credentialing committee. MCS must submit revised credentialing policies to the Regional Office for review. MCS must submit credentialing committee minutes for six (6) months with attendance sheets reflecting committee members with title and affiliations.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	MCS must develop and implement the following: 1) a corrective action plan which will outline the process that MCS will develop to ensure compliance with this element, 2) revise policies and procedures to reflect CMS guidelines, 3) present completed files to credentialing committee for review and approval, 4) provider manual list FDA approved mammography centers under a separate heading. Submit revised manual to Regional Office for review, 5)develop audit tool and monitor on a monthly basis facility credentialing, 6) develop a recredentialing policy and audit tool, 7) revise policy to reflect FDA approved mammography facilities, 8) incorporate member complaints, UM, or provider issues into recredentialing. MCS must submit to the CMS Regional Office revised credentialing policies and credentialing manual for review by March 2008.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 06 - Provider Relations	No Prohibition on Health Care Professional Advice to PatientsAn MAO may not prohibit a health care professional from advising or advocating on behalf of a patient.	MCS must revise policy and procedure to reflect appropriate language in the regulation. Submit policy and procedure to Regional Office for review. Update member handbook, member materials, provider manual, provider materials. Forward updated material to Regional Office March 2008.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	MCS must revise its policy and procedure to ensure that all members are notified of the organization's decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the complaint involves the Plan's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves Plan's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, then MCS must respond to an enrollee's grievance within 24 hours. MCS must also train all applicable staff members of the revised policy and procedures.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	MCS must revise its policy and procedures so that it issues notification of investigation results to all concerned parties as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 calendar days from the date the oral or written grievance is filed with the health plan.	Closed

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Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	In accordance with Medicare Guidelines, MCS and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper supporting documentation.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	In accordance with Medicare Guidelines, MCS and/or its delegated entity must pay 95 percent of clean claims from non-contracted providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the date of request. MCS must ensure that all clean claims exceeding 30 days are paid accordingly with interest.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	In accordance with Medicare Guidelines, MCS and/or its delegated entity must make correct claim determinations for services not payable and issue proper denials within 60 days of receipt. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation. Failure to issue a determination within the 60 day timeframe constitutes an adverse determination and the organization is obligated to send the case to the IRE for review.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	If the Plan or its designee decides to deny, discontinue, or reduce services or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The Plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	MCS must ensure that when an enrollee has made a request for a service, that they notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	If the Plan or its designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The Plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The standard denial notice must provide the specific reason for the denial and takes into account the enrollee's present medical condition, disabilities, and special language requirements, if any.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	MCS must ensure that when an enrollee has made a request for a service, they notify the enrollee of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after the organization receives the request for an expedited organization determination.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	MCS must establish and maintain procedures that establish efficient and convenient means for enrollees to submit oral/written requests for expedited organization determinations. MCS must document all oral requests in writing and maintain the documentation in the case file. MCS must promptly decide whether to expedite a determination based on whether applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Provide written notice of denials of requests for expedited determinations and instructions on how to file an expedited grievance when enrollees dispute the managed care denial or extension decision, and develop a meaningful process for receiving requests for expedited reviews. These procedures should include designating an office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited organization determinations. The procedures must be clearly explained in member materials. In addition, Medicare health plans will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other health plan offices are referred immediately to the Medicare health plan's designated office or department. The 72-hour period begins when the request is received by the appropriate office or department designated by the Medicare health plan regardless of whether the provider is under contract to the Medicare health plan. If the Medicare health plan requires medical information from non-contracted providers to make a decision, the Medicare health plan must request the necessary information from the non-contracted provider within 24 hours of the initial request for an expedited organization determination.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MAO must ensure that it processes unfavorable claims reconsiderations timely. In addition, it must ensure that its staff receives refresher training in order to correctly identify what it is an appeal and what is a reconsideration.	Closed

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Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	The MAO must ensure that it processes all unfavorable claims reconsiderations within the specified timeframes. In addition, MAO staff must receive refresher training on the appeals process. Please provide CMS with training schedule(s) and implementation timelines.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	Closed
Medical Card System, Inc.	1-787-758-2500 Ext. 2616	H4006	MA	Audit Findings	1/9/2008	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	The MAO must ensure that it follows the correct effectuation of Third Party Standard Pre-Service Reconsideration Reversals. If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision. If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Marion Polk must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Marion Polk must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack provisions for notifying authorized prescribers, network pharmacies, and pharmacists of negative formulary changes at least 60 days prior to the date the change becomes effective as well as a description of the methods used to provide notification of formulary changes. CMS reviewed the file "MPCHP Advantage Part D Formulary Upload Requirements." Because it was approved outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "MPCHP Advantage Part D Formulary Upload Requirements" contains provisions that demonstrate Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Marion Polk must revise its policies and procedures to include the following: - A provision for ensuring that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested along with written notice of the formulary change if the enrollees do not receive prior notice of a formulary change, and - A provision to provide retrospective written notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Marion Polk must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must provide CMS with documentation demonstrating the following: - Written notices of formulary change describe alternative drugs in the same therapeutic category, class or cost-sharing tier as the affected drug, and the expected cost-sharing for those drugs, and - Marion Polk authorizes a 60-day supply of the Part D drug under the same terms as previously allowed at the time a refill was requested if it does not provide the affected beneficiary with notice of formulary change 60 days before the change is effective.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Marion Polk must create policies and procedures for access to long-term care pharmacies that include a provision stating that Marion Polk must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in its service area that requests the contract. Marion Polk must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Marion Polk must revise its policies and procedures to include provisions for: - providing notice of "maintenance" and "other" formulary changes to entities providing other prescription drug coverage, and - providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must provide CMS with documentation demonstrating that it provides retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the Food and Drug Administration or removed from the market by the manufacturer.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Marion Polk must provide CMS with an analysis and explanation of why the universe submitted for WS-CN2_D, Required Contract Provisions: Long-Term Care Pharmacies, contained misclassified samples. Based on the analysis, Marion Polk must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Marion Polk must revise its policies and procedures to include the following: - A provision for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist, and - A provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must submit a template contract between itself/its PBM and each type of network pharmacy that includes a provision requiring pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception. Marion Polk must demonstrate that it is ensuring its network pharmacies are posting or distributing the "Medicare Prescription Drug Coverage and Your Rights" notice.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Marion Polk must revise its policies and procedures to include the following: - A provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals, - A statement that individuals who can request a standard or expedited coverage determination are the enrollee, the enrollee's appointed representative, on behalf of the enrollee, and the prescribing physician, and - A definition of a coverage determination in accordance with § 423.566(b)(1-5). Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack provisions for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. CMS reviewed the file "MPCHP Advantage Part D Appeals." Because it was approved outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "MPCHP Advantage Part D Appeals" contains provisions that demonstrate that Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element. Marion Polk must submit documentation to CMS demonstrating that it tracks the date of notification, the disposition of the request, and the date of disposition for exceptions, coverage determinations, and redeterminations.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Marion Polk must revise its policies and procedures to include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination that requires Marion Polk to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required for Marion Polk concerning the provision in its policies and procedures for notifying the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. CMS reviewed the files "MPCHP Advantage Part D Appeals" and "MPCHP Advantage Part D: Preauthorization Process for Part D Medications." Because these documents were approved outside the audit period, CMS did not review them to determine compliance with this element. However, CMS did determine that these documents contain provisions that demonstrate that Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element. Marion Polk must submit documentation to CMS demonstrating that it consistently notifies the enrollee of the coverage determination decision timely.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Marion Polk must develop policies and procedures for coverage determinations concerning payment that include the following: - A provision stating that, for an exceptions request, Marion Polk must notify the enrollee of its determination no later than 72 hours after receiving the physician's supporting statement, - A provision stating that Marion Polk must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - A provision stating that Marion Polk must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and - A provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring Marion Polk to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Marion Polk must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Marion Polk must revise its policies and procedures to include a provision for providing written notice of any adverse coverage determination to the enrollee and/or other applicable party. Marion Polk must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Marion Polk must revise its policies and procedures to include provisions: - Stating that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and - Discussing Marion Polk's means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Marion Polk must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Marion Polk must update its policies and procedures to include the following provisions: - A provision stating that both oral and written notice must provide an explanation that Marion Polk must process the request using the 72 hour timeframe for standard determinations, - A provision stating that both oral and written notice must inform the enrollee of the right to file an expedited grievance, - A provision stating that both oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support, and - A provision stating that both oral and written notice must provide instructions about Marion Polk¿s grievance process and its timeframes. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Marion Polk must revise its policies and procedures to include the following provisions: - A provision stating that Marion Polk must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement, - A provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring Marion Polk to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - A provision stating that Marion Polk must inform the enrollee within 24 hours when the case is forwarded to the IRE. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Marion Polk must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Marion Polk must revise its policies and procedures to include provisions stating that: - An enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception (the enrollee or the enrollee's appointed representative is also able to file a non-formulary exception request, which Marion Polk already states in its policies and procedures), and - The prescribing physician¿s statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of Marion Polk's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee¿s disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - If Marion Polk makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, and - If Marion Polk is waiting on a physician's statement in support of a formulary exception request, Marion Polk must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack provisions stating that it: (1) Must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and (2) Must grant a formulary exception when it determines that one of the three aforementioned factors has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. Marion Polk must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee¿s prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If Marion Polk does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Marion Polk must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Marion Polk must revise its policies and procedures to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	No corrective action is required on Marion Polk's notice for informing enrollees about inquiries involving excluded drugs. CMS reviewed the file "GV01_SNP Rx Notice of Inquiry.pdf." Because the notice has an approval date after the end of the audit period, CMS did not review the template to determine compliance with this element. However, CMS determined that "GV01_SNP Rx Notice of Inquiry.pdf" is consistent with the CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug and that it demonstrates Marion Polk currently has a notice template that is compliant with the requirements of this element. Marion Polk must revise its policies and procedures to include provisions for promptly and correctly categorizing incoming complaints as inquiries, grievances or coverage determinations/appeals. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must provide documentation to CMS that illustrates Marion Polk is correctly categorizing complaints as grievances, coverage determinations/appeals or inquiries. In addition, Marion Polk must provide documentation showing that it notifies enrollees whether their complaint is subject to grievance or coverage determination processes, per CMS requirements.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Marion Polk must revise its policies and procedures to include a provision for marking quarterly reports of all data requested in "Reporting Requirements: Grievances." Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must provide documentation of its systems demonstrating that Marion Polk tracks and stores the disposition of the grievance and the date the enrollee was notified of the disposition.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	No corrective action is required on Marion Polk's policies and procedures that lack a provision for training relevant staff on grievance policies and procedures. CMS reviewed the file "MPCHP Advantage Grievances Part D." Because it was approved after the end of the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "MPCHP Advantage Grievances Part D" contains provisions that demonstrate Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element. No corrective action is required on Marion Polk's training documentation. CMS reviewed the sign-in sheets in the file "MPCHP Advantage Grievance and Appeals Training." Because the documentation was dated after the end of the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that Marion Polk has and implements training on grievance policies and procedures for staff and contractors (if applicable).	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Marion Polk must revise its policies and procedures to include the following: - A provision stating that all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, - A provision stating that the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if Marion Polk justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - A provision stating that the enrollee must immediately be notified in writing when Marion Polk extends the deadline for resolving the grievance. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must provide documentation to CMS that demonstrates it adjudicates enrollee grievances fully and notifies the enrollee of the grievance disposition.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Marion Polk must provide documentation to CMS that demonstrates it notifies the enrollee of the grievance disposition. When notifying the enrollee of the grievance disposition, Marion Polk must adhere to the requirements that written grievances must be responded to in writing, any oral grievances in which an enrollee requests written response must be responded to in writing, and all grievances related to quality of care issues must be responded to in writing regardless of how the grievance was submitted.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Marion Polk must revise its policies and procedures to include a statement of Marion Polk's commitment to cooperating with the QIO in resolving grievance cases. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	No corrective action is required on Marion Polk's policies and procedures. CMS reviewed the file "MPCHP Advantage Grievances Part D." Because it was approved after the end of the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "MPCHP Advantage Grievances Part D" contains provisions that demonstrate Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Marion Polk must revise its policies and procedures to include a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Marion Polk must revise its policies and procedures to include a provision stating that any additional medical information Marion Polk requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack a provision stating that that the decision to accept or deny an expedited redetermination request is based on the enrollee's request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function. CMS reviewed the file, "CD02a_MPCHP Advantage Part D Appeals.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "CD02a_MPCHP Advantage Part D Appeals.doc" contains provisions that demonstrate that Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Marion Polk must revise its policies and procedures to include a provision stating that Marion Polk must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Marion Polk must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Marion Polk must update its policies and procedures to include a provision stating that Marion Polk must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Marion Polk must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must provide CMS with documentation demonstrating that Marion Polk provides enrollees with the notice, Request for Reconsideration, for denied redeterminations concerning drug benefit. Marion Polk must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, Request for Reconsideration). If Marion Polk does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Marion Polk must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Marion Polk to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CMS reviewed the file, "CD02a_MPCHP Advantage Part D Appeals.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "CD02a_MPCHP Advantage Part D Appeals.doc" contains provisions that demonstrate that Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Marion Polk must update its policies and procedures to include a provision stating that Marion Polk must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Marion Polk must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, Request for Reconsideration). If Marion Polk does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Marion Polk must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack: - A provision stating that for redeterminations favorable to the enrollee, Marion Polk must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, and - A provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Marion Polk to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CMS reviewed the file, "CD02a_MPCHP Advantage Part D Appeals." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "CD02a_MPCHP Advantage Part D Appeals" contains provisions that demonstrate that Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Marion Polk must revise its policies and procedures to include provisions stating that: - A provision indicating that notification of a favorable decision may be made orally or in writing, - A provision indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, - A provision stating that medical information must be requested within 24 hours of the enrollee¿s initial request, and - A provision stating that Marion Polk must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Marion Polk must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Marion Polk must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, Request for Reconsideration). If Marion Polk does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Marion Polk must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Marion Polk to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CMS reviewed the file, "CD02a_MPCHP Advantage Part D Appeals.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "CD02a_MPCHP Advantage Part D Appeals.doc." contains provisions that demonstrate that Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Marion Polk must submit documentation demonstrating that it uses appropriate personnel to conduct redeterminations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Marion Polk must update its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. Marion Polk must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack a provision stating that case files must be sent the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. CMS reviewed the file, "CD02a_MPCHP Advantage Part D Appeals.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "CD02a_MPCHP Advantage Part D Appeals.doc" contains provisions that demonstrate that Marion Polk has corrected the aforementioned deficiency in its policies and procedures that CMS is citing for this element.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	No corrective action is required on Marion Polk's policies and procedures. CMS reviewed the file, "CD02a_MPCHP Advantage Part D Appeals.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "CD02a_MPCHP Advantage Part D Appeals.doc" contains provisions that demonstrate that Marion Polk has corrected the aforementioned deficiencies in its policies and procedures that CMS is citing for this element.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Marion Polk must revise its policies and procedures to include a provision stating that payment must be made no later than 30 days from the date it receives notice reversing the decision. Marion Polk must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Marion Polk's policies and procedures that lack: - A provision stating that payment must be authorized within 72 hours from the date Marion Polk receives notice reversing the decision, and - A provision stating that a notice must be sent informing the IRE of the effectuation. CMS reviewed the file, "CD02a_MPCHP Advantage Part D Appeals.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "CD02a_MPCHP Advantage Part D Appeals.doc" contains provisions that demonstrate that Marion Polk has corrected the aforementioned deficiencies in its policies and procedures that CMS is citing for this element.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA-PD	Audit Findings	1/8/2008	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	No corrective action is required on Marion Polk's policies and procedures. CMS reviewed the file, "CD02a_MPCHP Advantage Part D Appeals.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "CD02a_MPCHP Advantage Part D Appeals.doc" contains provisions that demonstrate that Marion Polk has corrected the deficiencies in its policies and procedures that CMS is citing for this element.	Closed
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Colorado Access must identify the process and update applicable Policies and Procedures to include provisions for ongoing monitoring of individuals who perform marketing on behalf of the organization. Revised policies and procedures must be submitted to CMS.	Closed
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Colorado Access must update its policies and procedures regarding access to long-term care pharmacies to include the required provisions for long-term care contracting. Revised policies and procedures must be submitted to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Colorado Access must revise its policies and procedures to include a provision for retrospective notice to CMS and entities providing other prescription drug coverage in accordance with CMS requirements. Revised policies and procedures must be submitted to CMS.	Closed
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Colorado Access must amend its direct long-term care contracts to include all required provisions. CMS provided Long Term Care Pharmacy guidelines entitled "Long Term Guidance" which lists the minimum performance and service criteria that LTC pharmacies must meet in order to be a Part D pharmacy in its LTC network. This guidance is located at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/LTCGuidance.pdf. The amended contract template and associated signature pages must be submitted to CMS for review.	Closed
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Colorado Access must update policies and procedures to include a provision for documenting all oral requests for expedited redeterminations in writing and maintaining the documentation in the case file. Update policies and procedures to include a telephone number for oral requests for expedited redeterminations. Revised policies and procedures must be submitted to CMS.	Closed
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Colorado Access must update its policies and procedures to include a provision stating that any additional medical information the Part D sponsor requires must be requested within 24 hours of receiving the initial request for expedited determination. Revised policies and procedures must be submitted to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Colorado Access must update its policies and procedures to include a provision stating that notification of a favorable decision regarding expedited redeterminations may be made orally or in writing. Update policies and procedures to include a provision stating that medical information must be requested within 24 hours of the enrollee's initial request for an expedited redetermination. Revised policies and procedures must be submitted to CMS.	Closed
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Colorado Access must update policies and procedures to include provisions for effectuating third party reversals on an appeal of a request for a benefit. Revised policies and procedures must be submitted to CMS.	Closed
Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Colorado Access must update its policies and procedures to include provisions for effectuating third party reversals on an appeal of a request for payment. Updated policies and procedures must be submitted to CMS.	Closed

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Colorado Access	1-720-744-5675	H0621	MA-PD	Audit Findings	12/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Colorado Access must update policies and procedures to include provisions for effectuating third party reversals on an appeal of an expedited request for a benefit. Revised policies and procedures must be submitted to CMS.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The Plan must develop a program that ensures that agents/brokers are adequately trained, monitored, and evaluated. The program should include: * Initial new hire training manual * Type and content of all subsequent trainings * How Plan will ensure knowledge and understanding of program requirements * If written tests are implemented, indicate expected answers, passing score, number of times a test can be taken and how you will re-educate on deficient areas * A process for ensuring that agents/brokers are informed of current program updates The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The program should include documentation in each agent/broker file of at least the following: * Evidence of current licensure * Date of hire * Evidence of attendance at trainings * Evidence of knowledge and understanding of Medicare and the Plan * Evaluation of presentation skills * Information regarding rapid disenrollment * Information about any sales complaints from current or proseptive members * Information regarding disciplinary actions * Evidence of continued monitoring * Evidence of annual evaluation * Commission structure Revise policies to accurately reflect current practice. At least the following policies and forms need to be updated: * AA402 * AA403 * "Ride A long" form * Sales Performance Improvment Plan * Policy regarding required number of monthly sales	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.	Provider Network listings need to indicate contracted providers for all CMS required Providers and Specialists indicated in HSD Table 1 and contracted provider facilities indicated in HSD Table 3. Areas of concern are indicated by those areas listed in HSD Table 1 showing 0 providers and where there are no providers indicated, with the lack of an X, in HSD Table 3. Please explain this situation for each and every healthcare provider this affects. Please keep in mind that in developing your response, any explanation for having members travel outside of the pattern of care to obtain services is not acceptable. For areas where you cannot provide an acceptable delivery of services within CMS guidelines, please provide your plan to contract for the services within the county and/or within local Pattern of Care as required. Should there not be existing providers within any particular county, CMS expectations are that Colorado Access will describe how services will be made available within the local pattern of care, in adjacent counties, with contracted providers. Under certain conditions, when providers do not exist, referring the membership to a neighboring county, provided it is the existing pattern of care, can be acceptable. If Colorado Access plans on providing these services with a healthcare provider within a neighboring county, the provider in the neighboring county must be under contract. As the Colorado Access supplemental benefit for transportation is not a benefit that can be guaranteed from year to year, relying on this supplemental benefit to make healthcare providers available outside the pattern of care, is not acceptable.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	PCP Panel Established and Maintained - The MAO establishes, maintains, and monitors a panel of primary care providers from which the member may select a personal primary care provider.	Provider Networks listings need to indicate contracted providers for all CMS required Providers indicated in HSD Table 1. Areas of concern are indicated by those areas listed in HSD Table 1 showing 0 providers. Please explain this situation for each and every healthcare provider this affects. Please keep in mind that in developing your response any explanation that any plan for having members travel outside of the pattern of care to obtain services is not acceptable. For areas where you cannot provide an acceptable delivery of services within CMS guidelines, please provide your plan to contract for the services within the county and/or within local Pattern of Care as required. Should there not be existing providers within any particular county, CMS expectations are that Colorado Access will describe how services will be made available within the local pattern of care, in adjacent counties, with contracted providers. Under certain conditions, when providers do not exist, referring the membership to a neighboring county, provided it is within the existing pattern of care, may be acceptable. If Colorado Access plans on providing these services with a provider within a neighboring county, the provider in the neighboring county must be under contract. As the Colorado Access supplemental benefit for transportation is not a benefit that can be guaranteed from year to year, relying on this supplemental benefit to make healthcare providers outside the pattern of care available, is not acceptable.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Member Health Record Uses Established StandardsAll MAOs that offer CCPs must ensure that each provider furnishing services to members maintains member health records in accordance with standards established by the MAO, which take into account professional standards.	Colorado Access needs to establish policies and procedures for Medical Record Audits to include the required information and submit a copy of the policy and procedure to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 05 - Quality Assurance	Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).	Colorado Access is to provide evidence to the evaluation entity, MAQRO, that clearly defined criteria have been established for identifying members for the CCIP. Colorado Access is to provide evidence that a systematic process is being implemented to identify CCIP-eligible members based on the defined criteria. Colorado Access is to define valid quantitative measure(s) to assess program performance. Submit the measure description(s), including numerator and denominator, to the MAQRO evaluator.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 06 - Provider Relations	Consultation with Physicians and Subcontracted Physician Groups - The MAO must establish a formal mechanism to consult with the physicians and subcontracted groups that have agreed to provide services regarding the organization's: medical policy, quality assurance programs, and medical management procedures.	Re-write CCS 307 to include provisions for communicating practice guidelines to providers and enrollees including discharge criteria, continued stay, and admission practice guidelines to mirror the tasks and reporting mechanisms as described in the credentialing manager job description.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	In order to demonstrate compliance with Credentialing Requirements for Physicians and Other Health Care professionals, Colorado Access must develop and establish a Quality Improvement process which encompasses a formal process for reviewing performance indicators including: utilization management system, grievance system, enrollee satisfaction surveys, and other activities of the organization. The corrective action must include regular internal auditing of credentialing files including but not exclusive to Quality of Care Issues.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 06 - Provider Relations	Discrimination Against Health Care Professionals ProhibitedAn MAO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.	Colorado Access must amend Policy and Procedure CR301 to demonstrate there is not discrimination against Health Care Professionals based on those who serve high-risk populations or who specialize in the treatment of costly conditions.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 11 - Contracts	Required Contract Provision: Prompt PaymentThe MAO's written contracts with first tier and downstream entities must contain a prompt payment provision.	Colorado Access needs to ensure that all downstream contracts contain the proper wording, to come into compliance with CMS requirements, specifically a prompt payment provision. Please describe your plan for correction.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 11 - Contracts	Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.	Colorado Access needs to ensure that all downstream contracts contain the proper wording to come into compliance with CMS requirements, specifically wording related to a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO. Please describe your plan for correction.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	MAO needs to ensure that all downstream contracts contain the proper wording to come into compliance with CMS requirements, specifically wording related to a provision to show that the contracting entity will, comply with Medicare laws, regulations, reporting requirements, and CMS instructions, agree to audits and inspection by CMS and/or its designees, cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years. Please describe your plan for correction.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.	Colorado Access needs to ensure that all downstream contracts contain the proper wording on Compliance with MAO's Policies and Procedures, indicating that the MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures. Please describe your plan for correction.	Closed

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Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions for Deemable Activities: Delegation RequirementsThe MAO's written contracts with any entity that performs deemable activities that are delegated under its contract with CMS must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation.	Colorado Access needs to ensure that all downstream contracts contain the proper wording to come into compliance with CMS requirement. Specifically this means wording related to Delegation Requirements, indicating that the MAO's written contracts with any entity that performs deemable activities that are delegated under its contract with CMS, must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation. Please describe your plan for correction.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions for Non-Deemable Activities: Delegation RequirementsThe MAO's written contracts with any entity that performs non-deemable activities that are delegated under its contract with CMS must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation.	Colorado Access needs to ensure that all downstream contracts contain the proper wording to come into compliance with CMS requirements. Specifically wording related to Delegation Requirements, that the MAO's written contracts with any entity that performs non-deemable activities, that are delegated under its contract with CMS, must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation. Please describe your plan for correction.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must revise the following policies and procedures: a) Identifying and adjudicating clean claims within 30 days and b) Interest payment calculation. Although the MAO provided CMS with a process for reporting interest and penalties which was updated after the on-site review, we recommend that the MAO implement this process to ensure that all clean claims are paid within 30 days and, if not, interest is correctly calculated and paid to the provider.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Colorado Access must establish policies and procedures to include provisions that ensure the following: 1. That denial notices are sent to enrollees in all cases where the enrollee has financial liability for the services. 2. That claims are denied for the correct reason. 3. That descriptions of services in the denial letter are clear, accurate, and understandable to enrollees (e.g., do not use abbreviations, clinical language, etc.) The MAO must also conduct training of appropriate staff on the revised Policy and Procedure and submit documentation to the CMS Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	Colorado Access should create a relationship with facilities that serve their members. They should develop appropriate procedures to gather the required documentation related to the Termination of Provider Services, related to the termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF)Services. They must describe in their process and procedure how they will be able to provide a Detailed Explanation of Non-coverage of Provider Services (CMS 10095-B) in a timely manner. Please describe your plan for correction. CMS will follow-up no later than 3 months after the Process and Procedure has been accepted, and CMS will select another sample from a Colorado Access universe. This element will not be released until Colorado Access has acceptable performance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	Colorado Access should create a relationship with facilities that serve their members. They should develop appropriate procedures to gather the required documentation related to the Termination of Provider Services, related to the termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF)Services. They must describe in their process and procedure how they will be able to provide a Detailed Explanation of Non-coverage of Provider Services (CMS 10095-B) containing an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered, the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents, and other facts or information relevant to the non-coverage decision. Please describe your plan for correction. CMS will follow-up no later than 3 months after the Process and Procedure has been accepted, and CMS will select another sample from a Colorado Access universe. This element will not be released until Colorado Access has acceptable performance.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Colorado Access must establish policies and procedures to include provisions that ensure that denial notices, with appropriate appeal rights, are sent to enrollees in all cases where the enrollee has financial liability for any denied services.	Closed
Colorado Access	1-720-744-5675	H0621	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	Colorado Access must establish policies and procedures to include provisions that ensure that denial notices, with appropriate appeal rights, are sent to enrollees in all cases where the enrollee has financial liability for any denied services.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Marion Polk Community Health Plan Advantage (MPCHPA) must provide CMS with grievance data extracted from its Clinical Integration Management (CIM) system, the new software program used to track grievances. This data must include at a minimum, the date/time the grievance was received, date/time member notified of the resolution, whether the case was correctly categorized as a grievance or a coverage determination, whether or not the case was an expedited grievance, a brief description of the issue, whether the method of notification was correct along with a summary. MPCHPA must report for a period of 3 months or until CMS is satisfied that grievances are handled according to CMS guidance.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Marion Polk Community Health Plan Advantage (MPCHPA) must provide CMS with grievance data extracted from its Clinical Integration Management (CIM) system, the new software program used to track grievances. This data must include at a minimum, the date/time the grievance was received, date/time member notified of the resolution, whether the case was correctly categorized as a grievance or a coverage determination, whether or not the case was an expedited grievance, a brief description of the issue, whether the method of notification was correct along with a summary. MPCHPA must report for a period of 3 months or until CMS is satisfied that grievances are handled according to CMS guidance.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Marion Polk Community Health Plan Advantage (MPCHPA) must revise the member¿s grievance notification letter to include a description advising the member of their right to file a grievance with the QIO, a process that is totally separate from the plan¿s grievance process. MPCHPA¿s letter states that if the member is not satisfied that they can request a second level review with MPCHPA¿s Quality Improvement Committee but fails to mention this other process.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	12/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	Marion Polk Community Health Plan Advantage (MPCHPA) must provide CMS with grievance data extracted from its Clinical Integration Management (CIM) system, the new software program used to track grievances. This data must include at a minimum, the date/time the grievance was received, date/time member notified of the resolution, whether the case was correctly categorized as a grievance or a coverage determination, whether or not the case was an expedited grievance, a brief description of the issue, whether the method of notification was correct along with a summary. MPCHPA must report for a period of 3 months or until CMS is satisfied that grievances are handled according to CMS guidance.	Closed
Universal American Corp.	1-713-558-4694	H5421	MA	Ad-Hoc Compliance Event	12/19/2007	Closed	Chapter 99 - Ad-Hoc Compliance Event		Within 30 days of the date of this letter, you must submit a corrective action plan (CAP) that (1) fully describes the actions you will take to correct each deficiency, (2) include the date by which you expect the deficiency to be corrected, (3) describe how you will conduct ongoing compliance monitoring, and (4) include your revised polices and procedures.	Closed
Universal American Corp.	1-713-558-4694	H5421	MA	Ad-Hoc Compliance Event	12/19/2007	Closed	Chapter 99 - Ad-Hoc Compliance Event		Within 30 days of the date of this letter, you must submit a corrective action plan (CAP) that (1) fully describes the actions you will take to correct each deficiency, (2) include the date by which you expect the deficiency to be corrected, (3) describe how you will conduct ongoing compliance monitoring, and (4) include your revised polices and procedures.	Closed
Universal American Corp.	1-713-558-4694	H5421	MA	Ad-Hoc Compliance Event	12/19/2007	Closed	Chapter 99 - Ad-Hoc Compliance Event		Within 30 days of the date of this letter, you must submit a corrective action plan (CAP) that (1) fully describes the actions you will take to correct each deficiency, (2) include the date by which you expect the deficiency to be corrected, (3) describe how you will conduct ongoing compliance monitoring, and (4) include your revised polices and procedures.	Closed

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Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	12/12/2007	Closed	Chapter 05 - Quality Assurance	Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.	The MAO should review the QI Project Instructional Guide and the Medicare Managed Care Manual - Chapter 5: Quality Assessment and Improvement and Appendix B, Attributes of projects. The MAO must submit to MAQRO reviewers a QI project report that shows evidence that a 2007 QI project has been initiated, meeting Chapter 5 requirements. The MAO must use the CMS QI project report template and must complete the following sections: 1)MA Organization Information 2)QI Project General Information 3)Relevance of QI project Topic to Medicare Population 4)Quality Improvement Indicators and 5)Data Sources and Collection Methodology.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Gateway must revise its policies and procedures to include a provision for conducting ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide documentation demonstrating that its monitoring of both internal and external marketing representatives' marketing activities includes monitoring that marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Gateway must revise its executed contract and/or compensation structure used by its internal and external marketing representatives to include the following provisions: 1) a provision requiring that any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and 2) a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines, and all Federal health care laws (including civil monetary penalty laws).	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Gateway must provide CMS with an analysis and explanation of why the universe submitted for WS-MR4_D, Provision of Notices Regarding Formulary Changes, contained misclassified samples. Based on the analysis, Gateway must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Gateway must revise its policies and procedures to include a provision stating that it must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in its service area that requests the contract. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Gateway must revise its policies and procedures to address the requirement to provide retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	Gateway must revise its policies and procedures to include a provision for abiding by extensions to the transition period in accordance with CMS policy. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Gateway must revise its policies and procedures to include a provision for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist. Gateway must also revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must demonstrate that it is ensuring its network pharmacies are posting or distributing the "Medicare Prescription Drug Coverage and Your Rights" notice.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Gateway must revise its policies and procedures to include provisions for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing, and quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Policies and procedures need to also include a statement that individuals who can request a standard or expedited coverage determination are the enrollee, the enrollee's appointed representative, on behalf of the enrollee, and the prescribing physician. In addition, policies and procedures need to include a definition of a coverage determination in accordance with § 423.566(b)(1-5). Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Gateway must revise its policies and procedures to include the following: - a provision stating that Gateway must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination that requires the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Gateway must develop policies and procedures for coverage determinations concerning payment that include the following provisions: (1) Gateway must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, (2) Gateway must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (3) Gateway must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and (4) failure to notify the enrollee within the timeframe constitutes an adverse coverage determination that requires the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Gateway must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide documentation to CMS demonstrating that it provides timely notification to enrollees of its coverage determinations concerning payment.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Gateway must revise its policies and procedures to include a provision for providing written notice of an adverse coverage determination to the to the enrollee's appointed representative instead of the enrollee if the enrollee has identified an appointed representative. Gateway must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide documentation to CMS demonstrating that it uses a CMS-approved notice template for informing enrollees and/or applicable parties of adverse coverage determinations.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Gateway must revise its policies and procedures to include a telephone number of the designated office and/or department that receives both oral and written requests. Gateway must also revise its policies and procedures to include: - a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours, and - a provision stating that all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. Gateway must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Gateway must revise its policies and procedures regarding enrollee notification following a decision to deny a request for expedited coverage determination to include a provision for automatically transferring the request to the standard coverage determination process, giving the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently delivering (i.e., mailing) written notice to the enrollee within 3 calendar days. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Gateway must update its policies and procedures to include the following provisions: 1) a provision stating that both oral and written notice must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations, 2) a provision stating that both oral and written notice must inform the enrollee of the right to file an expedited grievance, 3) a provision stating that both oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and 4) a provision stating that both oral and written notice must provide instructions about the Part D sponsor¿s grievance process and its timeframes. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Gateway must revise its policies and procedures to include the following: (1) a provision stating that if the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification, (2) a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, (3) a provision stating that the Part D sponsor must inform the enrollee within 24 hours when the case is forwarded to the IRE. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Gateway must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. Gateway must also update its policies and procedures to include a provision stating that if oral notice is provided for adverse decision, the notice must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Gateway must revise its policies and procedures to include a provision stating that: - An enrollee's appointed representative shall be permitted to file a request for a non-formulary exception (the enrollee or the enrollee's prescribing physician is also able to file a non-formulary exception request, which Gateway already states in its policies and procedures), - The prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because the number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee¿s disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, - If Gateway makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - If Gateway is waiting on a physician's statement in support of a formulary exception request, Gateway must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception, and - Gateway must grant a formulary exception when it determines that the number of doses available under a dose restriction for the prescription drug (a) has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, and the drug would be covered but for the fact that it is an off-formulary drug. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Gateway must revise its policies and procedures to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Gateway must provide CMS with a CMS-approved or accepted notice for informing enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug). If Gateway does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Gateway must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must revise its policies and procedures to ensure they include provisions for promptly and correctly categorizing incoming complaints as inquiries, grievances or coverage determinations/appeals. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide documentation to CMS that illustrates Gateway is correctly categorizing complaints as grievances, coverage determinations/appeals or inquiries. In addition, Gateway must provide documentation showing that it notifies enrollees whether their complaint is subject to grievance or coverage determination processes, per CMS requirements.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Gateway must revise its policies and procedures to include a provision for tracking and maintaining, at a minimum, the date of receipt, disposition of the grievance, and the date that the enrollee was notified of the disposition. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide documentation of its systems that demonstrate Gateway tracks and stores the mode of receipt of the grievance and the person or entity filing the grievance.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	Gateway must develop policies and procedures regarding grievance process training that contain a provision for training relevant staff and contractors (if applicable) on grievance policies and procedures. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide documentation demonstrating that it has and implements training on grievance policies and procedures for staff and contractors (if applicable).	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Gateway must revise its policies and procedures to include the following: 1) a provision stating that all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, 2) a provision stating that the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if the Part D sponsor justifies a need for additional information and documents how the delay is in the interest of the enrollee, and 3) a provision stating that the enrollee must immediately be notified in writing when the Part D sponsor extends the deadline for resolving the grievance. In addition, Gateway must revise its policies and procedures to state that all grievances are resolved within 30 days after receipt. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide documentation to CMS that demonstrates it adjudicates enrollee grievances fully and within the timeframes required by CMS. Gateway must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance). If Gateway does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Gateway must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Gateway must provide CMS with a CMS-approved or accepted notice for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, Notice of Plan's Decision Regarding a Grievance). If Gateway does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Gateway must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Gateway must provide CMS with a CMS-approved or accepted notice for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, Notice of Plan's Decision Regarding a Grievance). If Gateway does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Gateway must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Gateway must revise its policies and procedures to include the telephone number for receiving oral requests from enrollees or their appointed representatives and a provision for maintaining documentation of expedited redetermination requests in a case file. Gateway must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Gateway must provide CMS with a CMS-approved or accepted notice for notifying an enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, Notice of Right to an Expedited Grievance). If Gateway does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Gateway must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Gateway must update its policies and procedures to include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination. Gateway must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide CMS with documentation demonstrating that Gateway provides enrollees with the notice, Request for Reconsideration, for denied redeterminations concerning drug benefit and makes decisions on standard redeterminations in a timely manner. Gateway must provide CMS with CMS-approved or accepted notices for providing notification on an adverse redetermination and for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notices, Notice of Redetermination and Request for Reconsideration, respectively). If Gateway does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Gateway must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Gateway must update its policies and procedures to include the following: - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination, and - a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Gateway must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway does not need to update its policies and procedures to include a provision stating that it must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. CMS reviewed the file, "(Medicare) Policy on Reconsideration for Drugs,revised 08.07.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "(Medicare) Policy on Reconsideration for Drugs,revised 08.07.doc" contains provisions that demonstrate that Gateway has corrected the deficiency in its policies and procedures that CMS is citing for this element. Gateway must provide CMS with CMS-approved or accepted notices for providing notification on an adverse redetermination and for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notices, Notice of Redetermination and Request for Reconsideration, respectively). If Gateway does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Gateway must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Gateway must revise its policies and procedures to include provisions stating that: - Gateway must notify the enrollee (and the prescribing physician involved, as appropriate) of its redetermination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after it received the request for an expedited redetermination, - Notification of a favorable decision may be made orally or in writing, and - Gateway must inform the enrollee, within 24 hours, when the case is forwarded to the IRE Gateway must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide CMS with CMS-approved or accepted notices for providing notification on an adverse redetermination and for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notices, Notice of Redetermination and Request for Reconsideration, respectively). If Gateway does not have a notice template that has been approved or accepted by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Gateway must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Gateway must provide CMS with documentation demonstrating that Gateway provide notices consistent with the CMS-issued model notices, Notice of Redetermination and Request for Reconsideration, for adverse expedited redeterminations.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Gateway must provide documentation to CMS demonstrating that it consistently forwards cases to the IRE timely.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	No corrective action is required on Gateway's policies and procedures. CMS reviewed the file, "(Medicare) Policy on Reconsideration for Drugs,revised 08.07.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "(Medicare) Policy on Reconsideration for Drugs,revised 08.07.doc" contains provisions that demonstrate that Gateway has corrected the deficiency in its policies and procedures that CMS is citing for this element. Gateway must demonstrate to CMS that it effectuates a decision that has been reversed by the IRE for cases concerning drug benefit within the timeframes required by CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Gateway must revise its policies and procedures to include a provision requiring a notice to be sent informing the IRE of the effectuation. Gateway must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. No corrective action is required on Gateway's policies and procedures that lack provisions for authorizing payment within 72 hours from the date Gateway receives notice reversing the decision and making payment no later than 30 days from the date Gateway receives notice reversing the decision. CMS reviewed the file, "(Medicare) Policy on Reconsideration for Drugs,revised 08.07.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "(Medicare) Policy on Reconsideration for Drugs,revised 08.07.doc" contains provisions that demonstrate that Gateway has corrected the aforementioned deficiencies in its policies and procedures that CMS is citing for this element.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA-PD	Audit Findings	12/11/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	No corrective action is required on Gateway's policies and procedures. CMS reviewed the file, "(Medicare) Policy on Reconsideration for Drugs,revised 08.07.doc." Because it was revised outside the audit period, CMS did not review it to determine compliance with this element. However, CMS did determine that "(Medicare) Policy on Reconsideration for Drugs,revised 08.07.doc" contains provisions that demonstrate that Gateway has corrected the deficiency in its policies and procedures that CMS is citing for this element.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	S4802	Part D	Ad-Hoc Compliance Event	12/10/2007	Closed	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	On September 6 and 7, 2007, the Centers for Medicare and Medicaid Services (CMS) conducted an on-site audit of Sterling to assess its ability to process enrollments provided by CMS for low income subsidy (LIS) eligible (including full benefit dual eligible) Medicare beneficiaries through both the automatic assignment of newly eligible LIS beneficiaries and the reassignment of LIS beneficiaries currently enrolled in prescription drug plans that will not qualify for LIS assignment in 2008. LIS beneficiaries are a particularly vulnerable beneficiary sub-population as they rely on the proper administration of the subsidy program to ensure that their Part D-related expenses are limited to the levels provided for under Medicare law. CMS has an obligation to insure that PDP sponsors that receive LIS autoenrollments and LIS reassignments provide Part D services in an efficacious manner. The purpose of this audit was to verify that Part D Sponsors can meet the unique needs of LIS beneficiaries participating in the reassignment or automatic enrollment processes. Request for a Corrective Action Plan (CAP) The audit identified the following three areas of concern. Those areas are: 1.Processing enrollment data accurately and in a timely manner (Performance Standards 1 and 2): 2.Providing responsive customer service (Performance Standard 3): and 3.Administering and executing the Best Available Evidence (BAE) Policy (Performance Standard 8). Processing Enrollment Data accurately and in a Timely Manner CMS requests a detailed plan of what automated systems Sterling has put in place to ensure that autoenrollment files are processed in an accurate and timely manner. This plan should include: - a description of how Sterling ensures sufficient staff are properly trained to load files in a timely manner: and - a description of how Sterling ensures that the proper files are loaded and processed (i.e., quality assurance): and -a time line for completion of training and changes in processing procedures. Providing Responsive Customer Service CMS has serious concerns regarding Sterling¿s call center operations. Sterling currently does not meet the 80% grade of service standard. Specifically, Part D Sponsors must demonstrate that 80% of incoming calls to their customer assistance call centers are answered within 30 seconds and that the abandonment rate does not exceed 5%. Further, Sterling¿s system, Destiny, does not support tracking (and aging) of customer service calls. Finally, Sterling did not demonstrate a robust plan for meeting the customer service call needs of beneficiaries if enrollment were to increase. CMS requests that Sterling provide a detailed plan and timeline that outlines how Sterling will: - Meet the 80% grade of service requirement: - Develop and implement a customer service call tracking and reporting system: and - Define how Sterling will meet customer staffing needs.	Closed

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									Administering and Executing the BAE Policy Finally, though Sterling is sufficiently staffed to meet current BAE research needs, CMS is concerned that staffing may not be sufficient to meet the beneficiary needs when enrollment increases. An increase in LIS eligible membership will, necessarily, increase the number of BAE exception cases. CMS requests that Sterling provide a detailed plan and timeline that outlines how Sterling will: - Develop and implement a process for researching BAE that considers the ability to consistently perform this task in 2008: - Develop and implement changes in their system(s) processing that allows for BAE overrides as well as maintains a history of information received for each enrollee: and - Meet short-term or long-term staffing needs for researching BAE for LIS status.	
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: - a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination; The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: - State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and - Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must be able to identify all requests for expedited coverage determinations. A request to expedite a coverage determination decision must be granted if the expedited request was made or supported by a physician, and the physician indicates either orally or in writing that applying the standard timeframes could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Additionally, WellCare must implement systems to address technician error that could lead to mislabeling of expedited coverage determination requests as standard requests. WellCare must provide documentation demonstrating this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must notify enrollees when a request to expedite a coverage determination is denied. Additionally, WellCare must implement systems to address technician error that could lead to mislabeling of expedited coverage determination requests as standard requests. WellCare must provide documentation demonstrating this to CMS.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees when a request to expedite a coverage determination is denied using a CMS compliant notice, consistent with Notice of Right to an Expedited Grievance. Additionally, WellCare must implement systems to address technician error that could lead to mislabeling of expedited coverage determination requests as standard requests. WellCare must provide documentation demonstrating this to CMS.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of all expedited coverage determination decisions and do so within CMS compliant timeframes. WellCare must provide documentation demonstrating this to CMS. Additionally, WellCare must forward the case file to the IRE in all instances that an enrollee is not notified of its expedited coverage determination decision within the required timeframe and provide documentation demonstrating this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: - if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, - WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, - WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) A ll covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or,(b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: - for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and - stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for standard drug benefit cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision and provide documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	S5967	Part D	Audit Findings	12/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for expedited drug benefit cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: -a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: -State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and -Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice,('Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: -if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, -WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, -WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and -if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance:or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional InformationF). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is	Open

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									adverse, WellCare must notify the enrollee using CMS compliant notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H0712	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: -a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: -State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and -Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: -States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. -Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. -Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: -if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, -WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, -WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and -if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is adverse, WellCare must notify the enrollee using CMS compliant notices. Specifically,	Closed

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									the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for standard drug benefit cases within the timeframes required by CMS and provide documentation demonstrating this to CMS.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: -a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: -State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and -Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: -States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. -Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. -Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: -if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, -WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, -WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and -if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is adverse, WellCare must notify the enrollee using CMS compliant notices. Specifically, the notices	Open

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									provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1903	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: -a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: -State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and -Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. H contracts: WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: -States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. -Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. -Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: -if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, -WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, -WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and -if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee,and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee,and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plan's Decision Regarding a Grievance¿), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee¿s health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is adverse, WellCare must notify the enrollee using CMS compliant notices. Specifically,	Open

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									the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination¿). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1112	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: - a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: - State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and - Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice,('Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: - if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, - WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, - WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance:or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional InformationF). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is adverse,	Open

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									WellCare must notify the enrollee using CMS compliant notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: -a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: -State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and -Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: -if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, -WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, -WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and -if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is	Open

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									adverse, WellCare must notify the enrollee using CMS compliant notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1416	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: -a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: -State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and -Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: -States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. -Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. -Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: -if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, -WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, -WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and -if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or,(b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice,`Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice,`Notice of Plan's Decision Regarding a Grievance'),then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is adverse, WellCare must notify the enrollee using CMS compliant notices. Specifically,	Open

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									the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H3361	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: -a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: -State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and -Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: - if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, - WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, - WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance:or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional InformationF). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: -for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and -stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is adverse,	Open

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									WellCare must notify the enrollee using CMS compliant notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (C7RX-039) to include provisions stating that: - failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - WellCare must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decisions and provide documentation demonstrating this to CMS. If WellCare fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, WellCare must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	WellCare must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following: - a provision stating that WellCare must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that WellCare must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	WellCare must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations (C7RX-039) to: - State that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and - Discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	WellCare must revise its policies and procedures regarding enrollee notification following decision to deny request for expedited coverage determination (C7RX-039) to include a provision stating that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request to expedite a coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (C7RX-039) to include: - a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring WellCare to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited coverage determination to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - Provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified samples. Based on the analysis, WellCare must provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (C7RX-038) to include provisions stating: - if WellCare requires a written statement from the enrollee's prescribing physician, it must do so immediately, - WellCare must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects, - WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if WellCare is waiting on a physician's statement in support of a tiering exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	WellCare must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (C7RX-038) to include: - a provision stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) A ll covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. - a provision stating that WellCare must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, - a provision stating that WellCare must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if WellCare is waiting on a physician's statement in support of a formulary exception request, WellCare must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	WellCare must revise its policies and procedures regarding determining cost-sharing for approved exceptions (C7RX-038) to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	WellCare must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If WellCare does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify the enrollee, or the appointed representative, as applicable, that a request is subject to either grievance or coverage determination procedures. WellCare must submit documentation demonstrating this to CMS. WellCare must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS. WellCare must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D, Expedited Coverage Determinations, contained misclassified cases. Based on the analysis, WellCare is to provide to CMS the root cause as well as a detailed corrective action plan.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	WellCare must provide CMS with a CMS-approved or accepted notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision to Extend the Deadline for Making a Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of grievance resolution using CMS compliant notices. Specifically, the notice must display the following in the lower left-hand corner: the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	WellCare must provide CMS with a CMS-approved or accepted notice template for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include provisions: - for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and - stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making standard redetermination concerning drug benefit decisions, WellCare must notify the enrollee in a timeframe that is CMS compliant. When a decision is favorable, WellCare must authorize or provide the benefit in a timeframe that is CMS compliant. When a standard redetermination concerning drug benefit decision is adverse, WellCare must notify the enrollee using CMS compliant notices. Specifically,	Open

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									the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. WellCare must provide documentation demonstrating this to CMS.	

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must notify enrollees of standard redetermination request decisions within timeframes that are CMS compliant using a CMS compliant Notice of Redetermination. If a decision timeframe is exceeded by WellCare, it must forward the case to the IRE as CMS requires. When notifying enrollees of adverse standard redetermination decisions, WellCare must also provide a CMS approved notice consistent with the Request for Reconsideration. For favorable decisions, WellCare must make payment within 30 calendar days. WellCare must provide documentation demonstrating this to CMS. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	WellCare must revise its policies and procedures regarding enrollee notification following the decision on an expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (C7RX-036) to include a provision stating that WellCare must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. WellCare must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Redetermination'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must provide CMS with a CMS-approved or accepted notice for when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'). If WellCare does not have a notice template that has been approved or accepted by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process or through the File and Use process, and provide evidence that it has done this for the purpose of this audit. WellCare must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When informing enrollees of adverse expedited redetermination decisions, WellCare must use CMS compliant notices consistent with the Notice of Redetermination and Request for Reconsideration and provide documentation demonstrating this to CMS.	Open

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from WellCare, WellCare must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation demonstrating this to CMS.	Open
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA-PD	Audit Findings	12/3/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	WellCare must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses WellCare's redetermination decision.	Open
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	The Part D sponsor or its PBM must develop and implement written policies and procedures that include the provisions required in the Prescription Drug Benefit Manual, Chapter 6, Section 30.3 and as stated in the deficiencies above. Provide a copy of the policies and procedures to CMS. The PBM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. The sponsor needs to provide a detailed description of how it will monitor compliance with these requirements.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	The Part D sponsor needs to: 1) revise the Amerigroup Corporation Marketing Integrity Program Special Needs Plan Addendum (and date it) with the appropriate language to show that this must be a written disclosure to enrollees, 2) develop policies and procedures for employees for providing the written disclosures to enrollees, 3) update contracts to include language for the written disclosures and prohibited marketing activities, 4) provide a detailed description as to how the sponsor will determine the brokers and sales agents are providing appropriate written disclosures to enrollees and are not partaking in prohibited marketing activities, and 5) conduct training of appropriate staff and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring.	Closed

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AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	The Part D sponsor needs to work with its PBM to update its policy and procedures FORMAD-0002 to include the provisions noted above in the deficiencies, or develop and implement new policies and procedures. Provide a copy of the policies and procedures to CMS. The PBM must conduct training of appropriate staff on the policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring of the PBM.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	The Part D sponsor or its PBM must develop and implement policies and procedures that include a provision stating that the PBM must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in its service area that requests the contract. The PBM must conduct training of appropriate staff on the policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Provide a copy of the policies and procedures to CMS.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	The Part D sponsor or its PBM must develop and implement policies and procedures that include the required provisions as shown in the deficiencies above. Provide a copy of the policies and procedures to CMS. The PBM must conduct training of appropriate staff on the policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring of the PBM.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	The Part D sponsor needs to work with its PBM to update its policy and procedures MEDAFF-0027 to include a provision to abide by extensions to the transition period in accordance with CMS' policy in the Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4.7. Provide a copy of the updated policies and procedures to CMS. The PBM must conduct training of appropriate staff on the policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. The sponsor must provide a detailed description of how it will ensure these requirements are met, including future monitoring of the PBM.	Closed

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AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	The Part D sponsor must conduct training of appropriate staff on the policies and procedures concerning Coverage Determinations and submit the documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being training. The sponsor must describe in detail the steps it is taking to ensure the compliance with these provisions, including future monitoring.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	The Part D sponsor must develop and implement policies and procedures on grievance process training which includes a provision for training relevant staff on grievance policies and procedures. The sponsor must conduct training of appropriate staff and submit documentation to CMS that details the nature of the training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The sponsor must describe the steps it is taking to ensure compliance with these requirements.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	The Part D sponsor must conduct training of appropriate staff on the grievance policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The sponsor must describe the detailed steps it is taking to ensure compliance with these provisions, including internal auditing.	Closed

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AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	The Part D sponsor must conduct training of appropriate staff on the grievance policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The sponsor must describe the detailed steps it is taking to ensure compliance with these provisions, including internal auditing.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	The Part D sponsor must conduct training of appropriate staff on policies and procedures concerning Standard Redeterminations and submit the documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being training. The sponsor must make sure the staff understands the timeliness standard of the notification and who must be notified of the decision. The Sponsor must describe the detailed steps it is taking to ensure the compliance with these provisions, including monitoring.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA-PD	Audit Findings	11/26/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	The Part D sponsor must conduct training on current policies and procedures to ensure the appropriate staff are educated on the procedures for sending case files to the IRE when they are requested. Submit the documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being training. The sponsor must describe in detail the steps it is taking to ensure compliance with these provisions, including future monitoring of staffs' actions.	Closed

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South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Create an action plan to ensure that all File and Use marketing pieces meet all Managed Care Marketing Requirements and are filed correctly as File and Use pieces. The MAO must identify and update marketing materials with the correct Customer Service hours of 8am to 8pm, 7 days a week. The MAO must provide the RO with a list of documents revised. The MAO must conduct training of appropriate staff on the File and Use policies and procedures. Please submit documentation to the regional office that details the nature of this training, to include: the materials used in the training, the individuals conducting the training, and the individuals being trained. File and Use pieces must not discuss detailed plan benefits. Hours of operations must be seven days a week. Applicable disclaimers must be listed. The Federal Government contracting statement needs to be corrected.	Closed
South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The Plan must develop a program that ensures that agents/brokers are adequately trained, monitored, and evaluated. The program should include: * Initial new hire training manual * Type and content of all subsequent trainings * How Plan will ensure knowledge and understanding of program requirements * If written tests are implemented, indicate expected answers, passing score, number of times a test can be taken and how you will re-educate on deficient areas * A process for ensuring that agents/brokers are informed of current program updates The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The program should include documentation in each agent/broker file of at least the following: * Evidence of current licensure * Date of hire * Evidence of attendance at trainings * Evidence of knowledge and understanding of Medicare and the Plan * Evaluation of presentation skills * Information regarding rapid disenrollment * Information about any sales complaints from current or proseptive members * Information regarding disciplinary actions * Evidence of continued monitoring * Evidence of annual evaluation * Commission structure	Closed

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South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Dakota Care must determine a standardized process for provider initial and recredentialing. Describe the actions Dakota Care is taking to assure it initially credentials and recredentials its contracted providers in accordance with CMS requirements. The corrective action must include regular internal auditing of credentialing files to assure compliance, which includes but is not limited to, review of the Medicare Opt Out list, Medicare/Medicaid Sanctions, and National Practice Database. Dakota Care must immediately develop, implement, and submit to CMS a credentialing oversight process to assure credentialing meets CMS requirements. The oversight process must include regular audits of credentialing files and include a corrective action process for any deficiencies found. Describe the resources that will be utilized that will help to ensure and maintain oversight and compliance.	Closed
South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Dakota Care must develop and implement written policies and procedures to identify a process to initially credential and recredential its contracted facilities. The process must include internal plan audits to assure compliance with CMS requirements. Dakota Care indicated they had not dedicated enough resources to ensure proper credentialing for its contracted facilities. Recommend increase in resources to meet compliance standard. Provide CMS with the new policies and procedures and plan for file review and correction, including timeline.	Closed
South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	The Plan must ensure that staff understand the difference between grievances and appeals. The plan should implement a process to audit this area until appeals and grievances are consistently differentiated. The Plan must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on the appeals and grievance policies and procedures. Submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Plan must ensure that grievance information is shared with appropriate departments so systemic problems can be corrected. For example any complaints regarding agents and brokers must be forwarded to the Sales and Marketing Director. Create a process to document the entire grievance case that includes the problem, the resolution and any organizational improvements that may be necessary.	Closed
South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	It is recommended that the Medicare Advantage Organization (MAO) conduct training of appropriate staff on the payment of 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt. Additionally, the MAO should establish a mechanism for ongoing monitoring of this area to ensure continued compliance by regularly reviewing aging reports for timeliness. It was noted during the review, that the claims that took so long to process were mostly out of state claims. CMS recommends that the MAO identify ways to ensure that the timeliness of claims from out of state providers is improved.	Closed
South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The Medicare Advantage Organization (MAO) must update their policy and procedures to ensure interest is paid on all clean non-contracting provider claims if not paid within 30 days of receipt. In addition, CMS recommends that the MAO conduct training to staff on its policy and procedures and to notify CMS via the corrective action plan of this training and its content.	Closed
South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The Medicare Advantage Organization (MAO) must ensure that all claims from non-contracting providers are paid or denied (adjudicated) within 60 calendar days of receipt. It is recommended that the MAO monitor monthly reports on the adjudication of non-contracting provider claims.	Closed

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South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The Medicare Advantage Organization (MAO) must ensure that staff understand the difference between grievances and appeals. The plan should implement a process to audit this area until appeals and grievances are consistently differentiated. The MAO must conduct training of its Customer Service staff, Appeals staff, and any other appropriate staff on the appeals and grievance policies and procedures. Submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must ensure that appeals information is shared with appropriate departments so systemic problems can be corrected. For example, claims being denied as routine lab tests, yet the lab tests are necessary for your chronic disease special needs plan.	Closed
South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	The corrective action required for this element is identical to the corrective action required for element RC01. The Medicare Advantage Organization (MAO) must ensure that staff understand the difference between grievances and appeals. The plan should implement a process to audit this area until appeals and grievances are consistently differentiated. The MAO must conduct training of its Customer Service staff, Appeals staff, and any other appropriate staff on the appeals and grievance policies and procedures. Submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must ensure that appeals information is shared with appropriate departments so systemic problems can be corrected. For example, claims being denied as routine lab tests, yet the lab tests are necessary for your chronic disease special needs plan.	Closed

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South Dakota Medical Association	1-605-334-4000 Ext. 3181	H5586	MA	Audit Findings	11/26/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	Update policy and procedure and implement step-by-step process to meet expedited reconsideration standards during weekends and holidays. Provide CMS with the new policies and procedures and plan for review and correction.	Closed

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Universal American Corp.	1-713-558-4694	H3333	MA	Ad-Hoc Compliance Event	11/21/2007	Closed	Chapter 99 - Ad-Hoc Compliance Event		UAFC must commence submitting routine retroactive actions to IntegriGuard effective immediately. UAFC must obtain clearance from Mark Holly and Wanda Blakely in the CMS Dallas Regional Office before making formal requests to the CMS Central Office to process batch file tapes. Please note that UAFC must continue submitting critical retroactive actions to Mark Holly, Wanda Blakely, and Marlon Bankston for handling. Standard Operating Procedures - UAFC must submit to CMS Dallas Regional Office for review and approval Standard Operating Procedures which clearly outline a process for submitting retroactive actions to IntegriGuard. UAFC must submit the Standard Operating Procedures to Mark Holly no later than Friday, December 7, 2007. Staff Training ¿ UAFC must train staff on Manual Chapter 2 and Standard Operating Procedures and provide Mark Holly with evidence of training no later than Friday, December 28, 2007.	Closed
Universal American Corp.	1-713-558-4694	H5421	MA	Ad-Hoc Compliance Event	11/21/2007	Closed	Chapter 99 - Ad-Hoc Compliance Event		UAFC must commence submitting routine retroactive actions to IntegriGuard effective immediately. UAFC must obtain clearance from Mark Holly and Wanda Blakely in the CMS Dallas Regional Office before making formal requests to the CMS Central Office to process batch file tapes. Please note that UAFC must continue submitting critical retroactive actions to Mark Holly, Wanda Blakely, and Marlon Bankston for handling. Standard Operating Procedures - UAFC must submit to CMS Dallas Regional Office for review and approval Standard Operating Procedures which clearly outline a process for submitting retroactive actions to IntegriGuard. UAFC must submit the Standard Operating Procedures to Mark Holly no later than Friday, December 7, 2007. Staff Training ¿ UAFC must train staff on Manual Chapter 2 and Standard Operating Procedures and provide Mark Holly with evidence of training no later than Friday, December 28, 2007.	Closed
Universal American Corp.	1-713-558-4694	H5421	MA	Ad-Hoc Compliance Event	11/19/2007	Closed	Chapter 99 - Ad-Hoc Compliance Event		1. UAFC must record in CTM the final disposition of the 935 complaints no later than Friday, November 30, 2007. 2. UAFC must conduct a root cause analysis of this issue, develop and implement process improvements, and submit a final report of these activities to Plan Manager Mark Holly no later than Friday, November 30, 2007.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Mercy Care must ensure that it's and/or its PBM's policies and procedures are revised to include (1) prescribing physicians (authorized prescribers) in the list of those notified of formulary changes 60 days in advance, and (2) provisions for issuing retrospective notice of formulary changes to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, including the means for doing so.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Mercy Care must describe the steps it is taking to become compliant with the requirements of this audit element and include as part of its correct action plan, the following: (1) Revise plan policies and procedures to include a provision that all sales representatives must be licensed or certified by the State. (2) Ensure that all sales representative files include copies of their contracts/agreements to abide by CMS requirements and that include the schedule under which they are compensated. (3) Ensure that all sales representatives, both internal and external, are licensed by the State Department of Insurance. (4) Describe plans to monitor external sales representative performance for compliance with CMS requirements.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Mercy Care must take the following action: (1) Revise its internal policy and procedures and/or ensure that its PBM updates its policy and procedure to specify that (a) if the plan does not provide a 60-day notice prior to a formulary change, it will provide affected enrollees with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested and provide written notice of the formulary change, and (b) if it removes a covered Part D drug immediately from the formulary because it is deemed unsafe by the FDA or the manufacturer removes the covered drug from the market, it provides retrospective notice to affected enrollees. (2) Describe the actions it will take to ensure that its PBM whose responsibility it is to notify affected members, complies with CMS notice requirements as specified in section 30.3.4 of Chapter 6 of the Medicare Part D Manual.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Mercy Care must ensure that its PBM revises its policy and procedure (Pharmacy Network Adequacy) to include a provision stating that it must offer standard contracting terms and conditions (including performance and service criteria for LTC pharmacies that CMS specifies) to any LTC pharmacy in Mercy Care's service area that requests a contract.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Mercy Care needs to work with its PBM to revise its policy and procedure to include a specific provision for- and a description of the means for notifying CMS, SPAPs and entities providing other prescription drug coverage, should Mercy Care need to remove a drug immediately from its formulary because the FDA has deemed it unsafe, or because the manufacturer removed it from the market.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	Mercy Care must ensure that policies and procedures are revised to include a provision to abide by extensions to the transition period in accordance with CMS policy.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	1) MCA must revise its policies and procedures regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include the following provisions: a) a provision for arranging with its network pharmacies to post or distribute the 'Medicare Prescription Drug Coverage and Your Rights' notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist, and b) a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices. MCA must clearly indicate in its policy and procedures if it conducts oversight of its contracted PBM to ensure that they are conducting ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. 2) MCA must provide CMS with a notice consistent with CMS-issued model notice, Medicare Prescription Drug Coverage and Your Rights. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	MCA must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to define coverage determinations in accordance with §423.566(b)(1-5). MCA must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	1) MCA must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit to include a provision stating that MCA must notify the enrollee (and the prescribing physician involved, as appropriate) of its decision regarding a coverage determination concerning drug benefit as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 2) MCA must explain what actions it will take to ensure that enrollees are notified timely of standard coverage determinations. The response should include documentation demonstrating that MCA has developed a process to ensure that the date and time the member is notified of standard coverage determinations is recorded. 3 MCA must provide CMS with a notice consistent with CMS-issued model notice, Notice of Case Status. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	1) MCA must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to include the following provisions that specifically address the requirements for coverage determinations concerning payment: a) a provision stating that MCA must notify the enrollee of its coverage determination regarding payment decision no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, and, b) a provision stating that for favorable coverage determinations concerning payment, MCA must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and c) a provision stating that for favorable coverage determinations concerning payment, MCA must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 2) MCA must explain what actions it will take to ensure that enrollees are notified timely of standard coverage determinations. The response should include documentation demonstrating that MCA has developed a process to ensure that the date and time the member is notified of standard coverage determinations is recorded. MCA also must explain what actions it will take to ensure that enrollee¿s requests for standard coverage determinations concerning payment that are not processed timely are forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe. The corrective action must include a detailed description of MCA¿s internal monitoring activities to ensure compliance with this element. 3) MCA must provide CMS with a notice consistent with CMS-issued model notice, Notice of Case Status. This notice should be submitted in HPMS for regional office review. Also include a copy of the notice with your Corrective Action Plan (CAP).	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	MCA must use a notice consistent with the CMS-issued model notice, Notice of Denial of Medicare Prescription Drug Coverage. The OMB control number must be displayed in the upper right hand corner of the notice, as required by CMS.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	MCA must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations to include the following provisions: a) the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, and b) a means for making expedited coverage determination decisions within the appropriate timeframe for requests received outside of normal business hours, and c) a provision that states that all oral requests must documented in writing and that documentation of request must be maintained in case file. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	MCA must revise its policies and procedures regarding enrollee notification following a decision to deny a request for expedited coverage determination to include the following provisions: a) a provision stating oral and written notice must inform the enrollee of the right to file an expedited grievance, and b) a provision stating oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and c) a provision stating oral and written notice must provide instructions about MCAs grievance process and its timeframes. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	1) MCA must explain what actions it will take to ensure that enrollees are notified timely of expedited coverage determinations. The response should include documentation demonstrating that MCA has developed a process to ensure that the date and time the member is notified of expedited coverage determinations is recorded. 2) MCA must revise its policies and procedures regarding enrollee notification following decisions on expedited coverage determinations to include a provision stating that MCA must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 3) MCA must provide CMS with a notice consistent with CMS-issued model notice, Notice of Case Status. This notice should be submitted in HPMS for regional office review. Also include a copy of the notice with your Corrective Action Plan (CAP).	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	MCA must revise its policies and procedures regarding enrollee notification following decisions on expedited coverage determinations to include the following provisions: a) a provision stating if the expedited coverage determination decision is adverse, MCA must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and b) a provision stating if oral notice is provided for adverse decision, the notice must satisfy the following requirements: - state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	MCA must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs to include the following provisions: a) a provision stating that an enrollee, an enrollee¿s appointed representative, or an enrolllee¿s prescribing physician shall be permitted to file a request for a non-formulary exception, and b) a provision stating that if the MCA makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, and c) a provision stating that the MCA must grant a formulary exception when it determines that one of the three factors needed in the prescribing physician¿s supporting statement has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, and d) a provision stating that MCA does not restrict the number of exception requests submitted per enrollee. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	1) MCA must revise its policies and procedures regarding approval of exceptions to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 2) MCA must review its exceptions authorization process to ensure that it is compliant with the requirement that enrollees not be required to request an approval following the initial prescription for the remainder of the plan year. Additionally, MCAs notices to the prescribing physician must be amended to remove any limitation on the number of fills that MCA is approving as well as any reference to an authorization expiration date.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	1) MCA must provide documentation to CMS demonstrating its communication methods for informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures (e.g., phone scripts and notice template for informing enrollees of complaint categorization) 2) MCA must conduct training of appropriate staff on correctly categorizing grievances and coverage determinations and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and individuals being trained. 3) MCA must provide CMS with a notice consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug. This notice should be submitted in HPMS for regional office review. Also include a copy of the notice with your Corrective Action Plan (CAP).	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	1) MCA must revise its policies and procedures regarding enrollee notification of grievance disposition to include a provision stating that the enrollee must immediately be notified in writing when MCA extends the deadline. MCA must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 2) MCA must explain what actions it will take to ensure that grievance outcomes are clearly explained on the grievance form. MCA must also explain what actions it will take to ensure that the notice to the enrollee of the plan's decision to extend the grievance deadline documents how the delay is in the best interest of the enrollee.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	MCA must revise its policies and procedures for accepting and addressing requests for expedited redeterminations to include the following provisions: a) the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals, and b) a provision for maintaining an efficient and convenient means for an enrollee or prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and c) a provision for maintaining documentation of expedited redetermination requests in a case file. MCA must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	1) MCA must explain what actions it will take to ensure that enrollees are notified timely of standard redetermination decisions concerning drug benefit. The corrective action must include a description of MCAs internal monitoring activities to ensure compliance with this requirement. MCA also needs to explain what actions it will take to ensure that enrollee¿s requests for redeterminations that are not adjudicated timely are forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe. The corrective action must include a detailed description of MCAs internal monitoring activities to ensure compliance with this element. MCA must explain what actions it will take to ensure that a Request for Reconsideration form is sent to enrollee with each adverse redetermination notice. 2) MCA must provide CMS with notices consistent with the following three CMS-issued model notices: Notice of Redetermination, Request for Reconsideration, and Notice of Case Status. These notices should be submitted in HPMS for regional office review. Please also include copies of the notices with your Corrective Action Plan (CAP).	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	1) MCA must explain what actions it will take to ensure that enrollees are notified timely of standard redetermination decisions concerning payment. The corrective action must include a description of MCAs internal monitoring activities to ensure compliance with this requirement. MCA also needs to explain what actions it will take to ensure that enrollee¿s requests for redeterminations that are not adjudicated timely are forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe. The corrective action must include a detailed description of MCA¿s internal monitoring activities to ensure compliance with this element. MCA must explain what actions it will take to ensure that a Request for Reconsideration form is sent to enrollee with each adverse redetermination notice. 2) MCA must provide CMS with notices consistent with the following three CMS-issued model notices: Notice of Redetermination, Request for Reconsideration, and Notice of Case Status. These notices should be submitted in HPMS for regional office review. Also include copies of the notices with your Corrective Action Plan (CAP).	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	1) MCA must explain what actions it will take to ensure that enrollees are notified timely of expedited redeterminations. The corrective action must include a description of MCAs internal monitoring activities to ensure compliance with this requirement. MCA also needs to explain what actions it will take to ensure that enrollee¿s requests for redeterminations that are not adjudicated timely are forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe. The corrective action must include a detailed description of MCAs internal monitoring activities to ensure compliance with this element. 2) MCA must provide CMS with notices consistent with the following three CMS-issued model notices: Notice of Redetermination, Request for Reconsideration, and Notice of Case Status. These notices should be submitted in HPMS for regional office review. Please also include copies of the notices with your Corrective Action Plan (CAP).	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	MCA must explain what actions it will take to ensure that it authorizes or provides the benefit within the required timeframe when the plan reverses, in whole, or in part, its coverage determination. The corrective action must include a description of MCAs internal monitoring activities to ensure compliance with this requirement.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	MCA must revise its policies and procedures regarding personnel conducting redeterminations to include the following provisions: a) a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination, and b) a provision stating that if the issue is a denial based on lack of medical necessity, then the Sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. MCA must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA-PD	Audit Findings	11/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	MCA must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the decision. MCA must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	Mercy Care must develop and submit as part of its CAP, materials for use in responding to requested disclosures of (1) Mercy Care's physician compensation methodologies, and (2) appeals and grievance data (Part C) in the format specified in Chapter 13 of the Medicare Managed Care Manual, Appendix 2.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Mercy Care must describe the actions it is taking to strengthen its oversight of sales representatives. Mercy Care's corrective action should describe measures for, (1) ensuring that all of its sales representatives are licensed by the State, including internal sales agents, (2)(3) conducting annual performance evaluations for all internal and external sales representatives. Evaluations should incorporate results of presentation evaluations (ride along reports), feedback from welcome calls and member complaint/disenrollment/retention logs, as well as any other reports that Mercy Care has developed to evaluate the performance of the sales representative. (4) setting internal performance standards for completion of training, ensuring that all sales representatives meet these standards and for documenting successful completion.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Mercy Care Advantage must describe the actions it is taking to ensure that it provides written notice to Medicare members 30 days prior to PCP or other provider terminations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits to ensure compliance with CMS requirements.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	Mercy Care Advantage must describe the actions it is taking to ensure that its delegated entities credential/recredential contracted providers in accordance with CMS requirements. Corrective action must include policy and procedure revisions for the health plan as well as its delegated entities. It must also include internal health plan audits as well as delegation oversight audits of credentialing files to ensure compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Mercy Care must initially credential all the non-credentialed Medicare contracted (PCN) physicians as soon as possible but no later than the end of 2007 (Mercy Care states that the PCPs will be credentialed at the November Credentialing Committee meeting). Mercy Care must credential the PCN specialists, both those with open authorizations and those without. In addition, Mercy Care must not assign any new members to the non-credentialed PCP panels and no new referrals to the non-credentialed specialists until credentialing is complete. Mercy Care must submit to CMS a list of all its Medicare contracted physicians (MDs, DOs, chiropractors and podiatrists) with the initial credentialing/recredentialing dates for each physician. Mercy Care Advantage must describe the actions it is taking to ensure that it and its delegated entities credential/recredential contracted providers in accordance with CMS requirements. Corrective action must include policy and procedure revisions for the health plan as well as its delegated entities. It must also include internal health plan audits as well as delegation oversight audits of credentialing files to ensure compliance.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Mercy Care needs to revise its desktop procedure to correctly describe processing of quality of care complaints that it receives directly.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Mercy Care must describe the steps it is taking to ensure that member service staff provides adequate grievance resolution notice to members, particularly when they receive and resolve complaints/grievances by phone. Documentation of complaints, actions taken and resolution notice needs to be strengthened. Corrective action should also include training if deemed necessary, and plans for monitoring compliance.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Mercy Care must describe the steps that it is taking to address the identified deficiencies. Corrective action should include at a minimum, the following: (1) Analysis and a correction of its EDI claims look-up to permit processors to view referring physicians, and an interim solution for claims development when services are from non-contracted providers such as laboratories, where it is unreasonable to expect that members would have walked into on there own without orders or a referral from a physician. (2) Changes in policy to pay non-contracted providers when members were referred to them from contracted providers. Mercy Care must also work with such identified referring physicians to ensure that they either changer referral patters and refer only to contracting providers, or obtain proper plan authorization prior to referring out of network. (3) Changes in claims processing and any necessary training, to include reasonable attempts to develop claims prior to denying them.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	Mercy Care must investigate and determine root cause(s) of identified underpayments/incorrect payments to non-contracting physicians (whether caused by Mercy Care's claims system or by processor errors). Corrective action should include a description of Mercy Care's analysis, the breadth of the problem, the steps Mercy Care is taking to resolve identified problems (including time-frames for completion of each step), and its ongoing monitoring plans to ensure that it pays non-contracted physicians and other providers appropriately at Original Medicare rates, when required.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Mercy Care must describe the actions that it is taking to ensure that it pays clean claims to non-contracted providers within 30 days of receipt. Corrective action should include an analysis of the non-compliant cases (#5, #6, #11, and #13) to determine why payment was late. It should also include a description of the steps Mercy Care is taking to address identified causes of delay as well as a description of Mercy Care's plans for monitoring its own performance for compliance on an ongoing basis.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Mercy Care must describe the actions that it is taking to ensure that it meets the requirements for this element. Corrective action must include at a minimum, the following: (1) Mercy Care must begin issuing denial notices that meet CMS requirements to members who receive services from non-contracted providers, when Mercy Care is not going to pay for the services in full (less Medicaid cost-sharing) under its AHCCCS or ALTCS contracts. (2) Revise the remittance advice appeal messaging so that non-contracted providers who want to appeal (request reconsideration) know which instructions to follow. Submit the EOB language to CMS for review and approval. (3) Submit a new claims denial notice that meets CMS requirements for review and approval ¿ not under the file and use certification process. (4) Review and revise the remittance advice format and develop additional messaging applicable for use with non-contracted providers. (5) Conduct training for all staff involved.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Mercy Care Advantage must describe the actions it is taking to ensure that it issues the CMS required NDMC or an RO-approved modification of the NDMC for adverse standard or expedited pre-service organization determinations. Corrective action must include internal health plan audits to ensure compliance with CMS requirements.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Mercy Care Advantage must describe the actions it is taking to ensure that it is meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Mercy Care Advantage must describe the actions it is taking to ensure that it issues the CMS required NDMC or an RO-approved modification of the NDMC for adverse standard or expedited pre-service organization determinations. Corrective action must include internal health plan audits to ensure compliance with CMS requirements.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Mercy Care must describe the actions that it is taking to ensure that it issues payments to effectuate its own overturn decisions within 60 days after it receives claim reconsideration requests, as required. Corrective action should also include a description of Mercy Care's plans for monitoring its own performance to ensure ongoing compliance.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	CMS usually requires organizations with misclassified samples to regenerate a new universe using the same audit period. However, in this case, because of other appeal processing deficiencies noted in this and other samples, CMS is requesting that Mercy Care generate a new universe for a later audit period - 6 months after CMS accepts the corrective action plan for other identified appeal processing deficiencies. Review of the newly generated universe will be conducted as part of a focused visit.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	CMS usually requires organizations with misclassified samples to regenerate a new universe using the same audit period. However, in this case, because of other appeal processing deficiencies noted in this and other samples, CMS is requesting that Mercy Care generate a new universe for a later audit period - 6 months after CMS accepts the corrective action plan for other identified appeal processing deficiencies. Review of the newly generated universe will be conducted as part of a focused visit.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member’s health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	Mercy Care must describe the steps that it is taking to ensure that it (1) notifies members of favorable standard pre-service reconsideration decisions it makes, and (2) authorizes these services, both within 30 days of receipt of standard pre-service reconsideration requests.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS’ independent review entity as expeditiously as the member’s health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	CMS usually requires organizations with misclassified samples to regenerate a new universe using the same audit period. However, in this case, because of other appeal processing deficiencies noted in this and other samples, Mercy Care must generate a new universe for a later audit period - 6 months after CMS' acceptance of corrective action for other identified appeal processing deficiencies. Review of the newly generated universe will be conducted as part of a focused visit.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member’s health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	CMS usually requires organizations with misclassified samples to regenerate a new universe using the same audit period. However, in this case, because of other appeal processing deficiencies noted in this and other samples, Mercy Care must generate a new universe for a later audit period - 6 months after CMS' acceptance of corrective action for other identified appeal processing deficiencies. Review of the newly generated universe will be conducted as part of a focused visit.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	Mercy Care must describe the methods that it is taking to ensure that staff provide notice to members (oral followed up by written notice, or simply written notice) as required within the required 72 hour timeframe, when it transfers expedited requests to the standard pre-service reconsideration process. Corrective action should also include Mercy Care's plans for monitoring ongoing compliance with this requirement.	Closed
Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	Mercy Care must take the following actions: (1) Submit a corrected notice for review and approval through HPMS and once approved, ensure that old versions of any unapproved notices are destroyed. (2) Conduct training for those who use appeal notices. (3) Describe plans for monitoring ongoing compliance.	Closed

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Southwest Catholic Health Network	1-602-453-6091	H5580	MA	Audit Findings	11/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	Mercy Care must take the following actions: (1) Develop and submit through HPMS, a notice to members that Mercy Care can use when it needs to extend its time-frame for making reconsideration decisions. Refer to the model notice in Appendix 5 of Chapter 13 in the Medicare Managed Care with the title, Notice of Right to an Expedited Grievance. (2) Conduct training for staff processing appeals. (3) Describe the plans that Mercy Care has for monitoring ongoing compliance of this requirement.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	S0043	Part D	Audit Findings	11/9/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	PMC must provide a Corrective Action Plan (CAP) which is consistent with CMS requirement and satisfies the delinquency noted above. PMC must employ sales/marketing representative who possess current, valid state licensures. PMC must provide a plan which instructs employed representatives to avoid incentives toward misleading beneficiaries, cherry picking certain beneficiaries or churning beneficiaries between plans. PMC must provide a plan which prohibits payments by person performing marketing to beneficiaries. PMC must provide a plan which provides a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short time frame (i.e. rapid disenrollment). PMC must provide employed sales/marketing representatives with the disclosure statement as follows: The person that is discussing plan options with you is either employed by or contracted with PMC. This person may be compensated based on your enrollment in PMC. PMC must provide a proof of a signed contract with sales/marketing representatives that are in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal healthcare laws.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	S0043	Part D	Audit Findings	11/9/2007	Open	Chapter 03: Marketing and Beneficiary Information	Requirements for Post-Enrollment Materials - The Part D sponsor must distribute post-enrollment materials as required by CMS, to each enrollee in a clear, accurate, and standardized form at the time of enrollment and at least annually thereafter. This information must be provided in writing, if requested. In addition, the Part D sponsor must provide written information about its grievance and appeals procedures and the process for quality of care complaints available to the enrollee through the Quality Improvement Organization (QIO) process.	PMC must provide a Corrective Action Plan (CAP) that is consistent with CMS guidelines concerning post enrollment materials. The CAP must include a plan, process and implementation of the said CAP which provides enrolled beneficiaries with enrollment materials on enrollment and annually thereafter.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Aveta, LLC.	1-787-622-3000 Ext. 5238	S0043	Part D	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	S0043	Part D	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	S0043	Part D	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	S0043	Part D	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	S0043	Part D	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	S0043	Part D	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	MMM must provide a CAP (Corrective Action Plan) consistent with the CMS guidelines for plan responsibility concerning persons employed or contracted to perform marketing. MMM must provide documented proof that all sales/marketing representatives have valid, current licenses. Provisional licensure must be documented and must include information concerning the ongoing progression and status for non provisional licensure. MMM must also provide updated, signed contracts with wording consistent with CMS¿s policy concerning prohibited payment from outside sources. In addition, MMM must show a plan which corrects the inconsistency and alters the format of sales/marketing representative file keeping. Sales/Marketing representative files must include a contract and that contract must include information concerning the following: Provision of disclosure statement Provision for coordinated marketing and compensation structures.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	MMM must submit a CAP inclusive of a method which provides beneficiaries with timely notices of formulary changes (at least 60 days prior to the date the change has become effective). MMM must also show documented proof that a beneficiary has been authorized to receive a 60 day supply of the affected formulary change drug.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance and appeals processes to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that member complaints are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA-PD	Audit Findings	11/9/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	PMC must provide a Corrective Action Plan (CAP) which is consistent with CMS guidelines for element MR06 Plan Responsibility for Persons Employed or Contracted to Perform Marketing. PMCs CAP must consist of and adhere to the following: 1.All sales/marketing representatives who must be licensed, certified, registered with current non expired documentation. This is true for individuals who are directly employed or contracted with PMC. 2.Provide a structure which avoids incentives toward misleading beneficiaries, cherry picking and/or churning beneficiaries between plans. 3.Provide a structure which prohibits payments by persons performing marketing to beneficiaries. 4.Inclusion of a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short time frame (i.e., rapid disenrollment). 5.PMC must train sales/marketing representatives that disclosure of the following is necessary when performing coordinated marketing: The person that is discussing plan options with you is either employed by or contracted with PMC. The person may be compensated based on your enrollment. 6.All coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities listed. In addition, this must include all Federal health care laws (including civil and monetary penalty laws).	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA-PD	Audit Findings	11/9/2007	Open	Chapter 03: Marketing and Beneficiary Information	Requirements for Post-Enrollment Materials - The Part D sponsor must distribute post-enrollment materials as required by CMS, to each enrollee in a clear, accurate, and standardized form at the time of enrollment and at least annually thereafter. This information must be provided in writing, if requested. In addition, the Part D sponsor must provide written information about its grievance and appeals procedures and the process for quality of care complaints available to the enrollee through the Quality Improvement Organization (QIO) process.	PMC must provide a Corrective Action Plan (CAP) consistent with the CMS policy concerning post enrollment materials and their distribution to Medicare beneficiaries. Post enrollment material must be given to beneficiaries upon enrollment into the plan.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances and appeals are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances and appeals are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA-PD	Audit Findings	11/9/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	PLAN must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PLAN should conduct an internal audit each month of its grievance process to assure that grievances and appeals are processed according to CMS requirements. This audit should evaluate whether your grievances and coverage determinations are being classified and handled appropriately within the required timeframes. PLAN should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.	MMM must ensure that it correctly identifies incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete. Policies and procedures must be revised to include this process.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS.	MMM must ensure that it issues Acknowlegment notices timely in accordance with 42 CFR 422.60(e)(3) and Manual Chapter 2, Section 40.4.1.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Notice Content) - The written acknowledgement notice, sent in response to the beneficiary's enrollment election, meets CMS requirements and specifies the correct effective date of enrollment.	While onsite, MMM staff made reference to new notices being entered into HPMS that included the updated language (i.e., OEP language. However, notices provided by Plan Manager, did not include the language and as a result, do not meet the CMS standards. Therefore, MMM must revise its Acknowledgement Notices in accordance with Chapter 2 of the Medicare Managed Care Manual. See Exhibit 4. The revised notice must be submitted to the Regional Office for review and approval.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	MMM must provide refresher training to its MA staff in the sales, membership and accounting, and customer service departments)on all Medicare Advatage election periods. Proof of such training must be submitted to the CMS Regional Office and must include: Attendance sheet and training course topics covered. Policies and procedures must be revised to include election period information as explained in Chapter 2 of the Medicare Managed Care Manual. MMM must pay particular attention to elections for dual eligible individuals which must be submitted utilizing the Special Enrollment Period (SEP) indicator for duals and the IEP for Part D. The revised policies and procedures must be submitted to the CMS Regional Office for review and approval.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	MMM must supply in all Marketing Representatives files the proper information relaying to adherence to the Elements of MR05. MMM must provide a Corrective Action Plan (CAP) establishing the following: Marketing Representatives files must include performance data consisting of extensive information regarding MMM's system and maintenance of said system, which confirms that enrolled members are enrolled into MMM's MA/MAPD plan and comprehend the rules applicable under that plan. MMM must also provide a CAP establishing a process and maintenance of the said process, which outlines a procedure to monitor Marketing Representative information concerning rapid disenrollment rates and request and/or completion of retroactive disenrollments to CMS.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	In order to comply with CMS guidelines, MMM must provide and adhere to a process which confirms that marketing and sales representatives do not engage in activities which mislead, confuse or misrepresent the organization. The process should also include documented, effective training intended to equipt beneficiaries and/or their representative with the tools to make educated decisions regarding enrollment. MMM must keep consistant records regarding the following: 1. Trainings and employee examinations. 2. Performance data, including adherence to quotas, etc. 3. Rapid disenrollments and cancelations, including request for retro disenrollments. 4. Supervisory warnings and/or disciplinary actions. In addition, MMM must contractually comply with CMS guidelines to employ sales and marketing respresentatives who are licensed. A ll representatives should not be allowed to carry out sales and marketing duties for MMM without a current, validated and/or non-expired license.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 04 - Benefits and Beneficiary Protections	Oversight of Delegated Entities with Chapter 4 Responsibilities - If any of the activities or responsibilities for the above elements in Chapter 4 are delegated to other parties, the MAO must oversee them per CMS standards.	MMM needs to review and revise its delegation policies as necessary to include oversight of all delegated entities. MMM is to submit a copy of such revised policies and procedures. MMM is to develop documentation form(s)that include all the elements that will be checked during the monitoring review. MMM is to submit the results of the initial monitoring. MMM is to provide a time table that shows how such monitoring will be continued and evaluated in the future.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	MMM needs to review and revise its policies and procedures as necessary so that all of the required information is available to the Credentialing Committee at the time the provider is reviewed for acceptance into the network. Submit such revised policies and or procedures to CMS. MMM is to submit a document that outlines the process it will implement to verify that recredentialing is done in a timely manner. MMM is also to submit a document that shows how it will monitor and evaluate the implementation of this process. MMM is to submit a document that describes the oversight process that MMM will implement to verify all credentialing requirements are met by its delegated entities. MMM is to implement a program to educate personnel involved in the credentialing process of this corrective action plan.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Due to the severity of the issues identified during the audit MMM is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that MMM has implemented an internal corrective action plan. MMM must conduct training of appropriate staff on appropriate identification of grievances, appeals and organization determinations. MMM must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, the individuals being trained, and methods of evaluation. CMS acknowledges MMM has begun implementing this process and has stated a completion date of 10/2007 Auditor notes that MMM has created a unit Quality and Production Scoring System (QPSS) to closely monitor grievance staff performance. The MCO should conduct monthly internal audits QPSS .The MCO should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the Regional Office within 15 days of th close of the quarter. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.¿ In addition, MMM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. MMM is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, MMM will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. MMM should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. MMM should submit the Universe to CMS no later than July 18, 2007 for sample selection.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Due to the severity of the issues identified during the audit MMM is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that MMM has implemented an internal corrective action plan. MMM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. MMM is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, MMM will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. MMM should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. MMM should submit the Universe to CMS no later than July 18, 2007 for sample selection.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Due to the severity of the issues identified during the audit MMM is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that MMM has implemented an internal corrective action plan. MMM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. MMM is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, MMM will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. MMM should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. MMM should submit the Universe to CMS no later than July 18, 2007 for sample selection.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	Due to the severity of the issues identified during the audit MMM is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that MMM has implemented an internal corrective action plan. MMM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. MMM is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, MMM will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. MMM should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. MMM should submit the Universe to CMS no later than July 18, 2007 for sample selection.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	In accordance with Medicare Guidelines, MMM must make correct claim determinations for services obtained from non-contracting providers. MMM must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event MMM is unable to secure the necessary information MMM from the provider, within the 30/60 day timeframe, MMM may utilize the 14 day extension provision with proper documentation.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	MMM must ensure that its delegated entities pay all clean claims exceeding 30 days are paid accordingly with interest.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	APS must submit a new universe consisting of all non-contracted provider claims submitted during the review period which were denied for the following reasons: 1. Non-emergent, 2. Non-urgent, 3. Out of area care, 4. Not a covered service 5. Unauthorized services. Exclude duplicate claims, adjustments to claims that were previously processed, and claims denied because the beneficiary was not enrolled in the MA/Cost Plan on the date of service. A claim consists of one or more services/line items with a unique bill date and a unique paid date. If one line item in the claim is denied, the claim belongs in this universe. There should be only one record in the universe for each entire claim (line items should be rolled up). MMM must ensure that its delegated entity APS submits this information in accordance with the aforementioned instructions.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	If the Medicare plan or it's designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The Standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any. MMM must ensure that it's delegated entities adhere to the aforementioned regulations.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Notice of Non-Coverage of Inpatient Hospital Care - The MAO must provide notice to the enrollee of its decision (or that of the delegated provider) of non-coverage of further hospital care no later than the day before hospital coverage ends when the enrollee disagrees with the discharge or noncoverage decision. Prior to issuance of this notice, the MAO secures concurrence from the physician responsible for the patient's care in the hospital. The MAO's notice of non-coverage of further inpatient hospital care must include the reason why further inpatient hospital care is no longer needed; the date and time of the enrollee's liability for continued impatient care; and the enrollee's appeal rights.	MMM is required to submit to CMS current notice of non-coverage of Inpatient Hospital Care for review and approval. Please ensure that the notice is approved through CMS Marketing process in HPMS.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	MMM must ensure that if it overturns it adverse organization determination denying an enrollee's request for payment, the organization will issue its reconsidered determination and send payment for the service to the enrollee or provider. This must be mailed no later than 60 calendar days from the date the plan received the request for standard reconsiderations .	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	MMM must ensure that if it affirms, in whole or in part, its adverse organization determination (i.e., continues to deny payment in whole or in part), it must prepare a written explanation and send the complete case file to the independent review entity contracted by CMS. This must be completed no later than 60 calendar days from the date it receives the request for reconsideration. MMM must make reasonable and diligent efforts to gather and forward information to the independent review entity. MMM must also notify the enrollee that the case has been forwarded to the independent review entity. If CMS determines that MMM's has a pattern of not making a reasonable and diligent effort to gather and forward information to the independent review entity, MMM will be considered in breach of its Medicare contract.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	MMM must ensure that if it overturns it adverse organization determination denying an enrollee's request for a service, the organization will issue an authorization for the service and notify the enrollee no later than 30 calendar days from the date the plan received the request for standard reconsideration.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	MMM must ensure that if makes a reconsidered determination that affirms in whole or in part, its adverse organiztion determination, it must prepare a written explanation and send the complete case file to the independent review entitity contracted by CMS. This must be completed as expeditiously as rhe enrollee's health condition requires but no later than 30 calendar days from the date it receives the request for standard reconsideration, or no later than the end of any extension. MMM must make reasonable and diligent efforts to gather and forward all pertinent information to the independent review entitiy. MMM must also notify the enrollee that the case has been forwarded to the independent review entitiy. If CMS determines that MMM's has a pattern of not making a reasonable and dilegent effort to gather and forward information to the independent review entitiy, MMM will be considered in breach of its Medicare contract.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	MMM must ensure that if makes a reconsidered determination that affirms in whole or in part, its adverse organiztion determination, it must prepare a written explanation and send the complete case file to the independent review entitiy contracted by CMS. This must be completed as expeditiously as rhe enrollee's health condition requires but no later than 30 calendar days from the date it receives the request for standard reconsideration, or no later than the end of any extension. MMM must make reasonable and diligent efforts to gather and forward all pertinent information to the independent review entitiy. MMM must also notify the enrollee that the case has been forwarded to the independent review entitiy. If CMS determines that MMM's has a pattern of not making a reasonable and dilegent effort to gather and forward information to the independent review entitiy, MMM will be considered in breach of its Medicare contract.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	MMM must establish a process to distinguish Part C and D requests. As such we are requesting that MMM submit a new universe for sampling which contains all requests for expedited pre-service reconsiderations received during the review period, whether or not they were expedited, excluding requests for drugs covered under the Part D program.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	MMM must establish a process to distinguish Part C and D requests. As such we are requesting that MM submit a new universe for sampling which contains all requests for expedited pre-service reconsiderations received during the review period, whether or not they were expedited, excluding requests for drugs covered under the Part D program.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4003	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.	MMM must establish a process to distinguish Part C and D requests. As such we are requesting that MM submit a new universe for sampling which contains all requests for expedited pre-service reconsiderations received during the review period, whether or not they were expedited, excluding requests for drugs covered under the Part D program.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.	CMS auditor notes that this was a deficiency in the 2005 post contract audit. PMC must provide a description of the new process developed to download, audit and process transaction reply codes received from CMS. PMC is also required to conduct training of appropriate staff responsible for this process. PMC must also submit documentation of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. To ascertain the effectiveness of the new process and training PMC must conduct internal audits on a monthly basis. PMC should submit a summary report once a quarter to the regional office of its monthly findings until futher notice beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Notice Content) - The MAO sends the disenrollment notice to the member in a format specified by CMS, providing the correct effective date of disenrollment.	PMC must ensure that appropriate language is included in the disenrollment letters sent to members. Please ensure that all notices to be used are approved through CMS Marketing system in HPMS.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Correct Enrollment Election - Elections must be completed by the beneficiary or representative.	In order to be compliant with CMS guidelines, PMC must ensure that all elections are properly signed and completed appropriately. This is inclusive to proper training of sales representatives, enrollment department and all other PMC employees who accept elections.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.	PMC staff must be provided with refresher training on the enrollment process. In addition, staff from all departments involved in the sales and processing of enrollments, must be trained on the Medicare Advantage enrollment election periods. Policies and procedures for all departments involved must be revised to include the complete enrollment election periods and process in accordance with 42 CFR 422.60(e) and the Medicare Managed Care Manual, Chapter 2, Section 40.2.2. They must be submitted to the CMS Regional Office for review and approval.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	PMC must ensure that elections are denied in accordance with 42 CFR 422.60(e)(3)and Chapter 2 of the Medicare Managed Care Manual Section 40.2.3. Staff must be provided with refresher training and policies and procedures must be revised to include the complete denial process. Proof of training must be provided. Revised policies and procedures must be submitted to the CMS Regional Office for review and approval.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Notice Content) - The denial notice meets CMS requirements. If the MA plan is currently enrolled to capacity, the notice explains the procedures that will be followed when vacancies occur.	PMC must ensure that it follows the correct procedure for denial of enrollment prior to transmission to CMS and that the notices it issues to the affected beneficiaries meet CMS requriements. Please refer ER07 for CAR.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.	PMC must promptly (and within the timeframes specified by CMS) notify beneficiaries in writing of CMS' acceptance or rejection of enrollment in accordance with 42 CFR 422.60(e)(3) and Medicare Managed Care Manual Section 40.4.2.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	PMC must revise ensure that the final notice of enrollment sent to the beneficiary, describing CMS' rejection of enrollment, meets CMS requirements in accordance with 42 CFR, Section 422.60(e)(3) and Medicare Managed Care Manual, Section 40.4.2. Final Notice of rejection and revised policies and procedures must be revised and submitted to CMS Regional Office for review and approval.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	PMC must supply in all Marketing Representatives files the proper information relaying to adherence to the Elements of MR05. PMC must provide a Corrective Action Plan (CAP) establishing the following: Marketing Representatives files must include performance data consisting of extensive information regarding PMC's system and maintenance of said system, which confirms that enrolled members are enrolled into PMC's MA/MAPD plan and comprehend the rules applicable under that plan. PMC must also provide a CAP establishing a process and maintenance of the said process, which outlines a procedure to monitor Marketing Representative information concerning rapid disenrollment rates and request and/or completion of retroactive disenrollments to CMS.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	In order to comply with CMS guidelines, PMC must provide and adhere to a process which confirms that marketing and sales representatives do not engage in activities which mislead, confuse or misrepresent the organization. The process should also include documented, effective training intended to equip representatives, and in tern, beneficiaries, with the tools to make educated decisions regarding enrollment. PMC must keep consistent records regarding the following: 1. Trainings and employee examinations. 2. Performance data, including adherence to quotas, etc. 3. Rapid disenrollments and cancellations, including request for retro disenrollments. 4. Supervisory warnings and/or disciplinary actions. In addition, PMC must contractually comply with CMS guidelines to employ sales and marketing representatives who are licensed. No representative should be allowed to carry out sales and marketing duties for PMC without a current, validated and non-expired license.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	PMC needs to review its policies and procedures and revise them as necessary so that all of the required information is available to the Credentialing Committee at the time the provider is reviewed for acceptance into the network. PMC is to submit such revised policies and or procedures to CMS. PMC is to develop an action plan regarding the oversight process that PMC will implement to verify that all credentialing requirements are met by its delegated entities. PMC is to submit this action plan to CMS. PMC is to implement a program to educate personnel involved in the credentialing process of this corrective action plan.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Due to the severity of the issues identified during the audit PMC is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that PMC has implemented an internal corrective action plan. PMC must conduct training of appropriate staff on appropriate identification of grievances, appeals and organization determinations. PMC must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, the individuals being trained, and methods of evaluation. CMS acknowledges PMC has begun implementing this process and has stated a completion date of 10/2007 Auditor notes that PMC has created a unit Quality and Production Scoring System (QPSS) to closely monitor grievance staff performance. The MCO should conduct monthly internal audits QPSS .The MCO should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the Regional Office within 15 days of th close of the quarter. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.¿ In addition, PMC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PMC is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, PMC will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. PMC should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. PMC should submit the Universe to CMS no later than July 18, 2007 for sample selection.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Due to the severity of the issues identified during the audit PMC is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that PMC has implemented an internal corrective action plan. PMC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PMC is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, PMC will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. PMC should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. PMC should submit the Universe to CMS no later than July 18, 2007 for sample selection.	Open

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Due to the severity of the issues identified during the audit PMC is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that PMC has implemented an internal corrective action plan. PMC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PMC is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, PMC will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. PMC should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. PMC should submit the Universe to CMS no later than July 18, 2007 for sample selection.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	Due to the severity of the issues identified during the audit PMC is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that PMC has implemented an internal corrective action plan. PMC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PMC is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, PMC will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. PMC should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. PMC should submit the Universe to CMS no later than July 18, 2007 for sample selection.	Open

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	In accordance with Medicare Guidelines, PMC and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation. MDN must submit a new universe consisting of all non-contracted provider claims submitted during the review period which were denied for the following reasons: 1. Non-emergent 2.Non-urgent 3.Out of area care, 4. Not a covered service 5.Unauthorized services. Exclude duplicate claims, adjustments to claims that were previously processed, and claims denied because the beneficiary was not enrolled in the MA/Cost Plan on the date of service. A claim consists of one or more services/line items with a unique bill date and a unique paid date. If one line item in the claim is denied, the claim belongs in this universe. There should be only one record in the universe for each entire claim (line items should be rolled up). PMC must ensure that MDN submits this information in accordance with the aforementioned instructions.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	In accordance with Medicare Guidelines, PMC and/or its delegated entity must pay 95 percent of clean claims from non-contracted providers within 30 calendar days of the request. Al l other claims must be paid or denied within 60 calendar days from the the date of request. PMC must also ensure that this process is followed when requesting and securing universe information from its delegated entities.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	In order to be compliant with CMS guidelines, PMC must implement a process where interest payments made to non-contracted providers are calculated correctly. In addition, this process must include a plan for proper record keeping of interest amounts and payments made.	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	In accordance with Medicare Guidelines, PMC and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation MDN must submit a new universe consisting of all non-contracted provider claims submitted during the review period which were denied for the following reasons: 1. Non-emergent 2.Non-urgent 3.Out of area care, 4. Not a covered service 5.Unauthorized services. Exclude duplicate claims, adjustments to claims that were previously processed, and claims denied because the beneficiary was not enrolled in the MA/Cost Plan on the date of service. A claim consists of one or more services/line items with a unique bill date and a unique paid date. If one line item in the claim is denied, the claim belongs in this universe. There should be only one record in the universe for each entire claim (line items should be rolled up). PMC must ensure that MDN submits this information in accordance with the aforementioned instructions.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	If the Medicare plan or it's designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enro llee has a representative, the representative must be sent a copy of the notice. The plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The Standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	CMS auditor notes that this was a deficiency in the 2005 post contract audit. Auditor notes that PMC has taken corrective action to address this issue however the following information must be submitted to asses the plan appropriately: (1) Flowchart of the revised process (2) Role, Function of the Health Services Quality Unit (3) Description and findings of the newly established internal audit program (4) Materials utilized for training, who conducted the training and list of staff that attended session. Also include method of evaluation utilized to determine staff understanding/comprehension. (5) Audit findings submitted on a quarterly basis of the monthly findings until futher notice beginning the fourth quarter of 2007. This report is due to the Regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor(s), the audit methodolosgy, and the result of the audit.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	PMC must establish a mechanism for ongoing monitoring of the department responsible for ensuring the required notices are disseminated within the appropriate time frames.	Open
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Notice of Non-Coverage of Inpatient Hospital Care - The MAO must provide notice to the enrollee of its decision (or that of the delegated provider) of non-coverage of further hospital care no later than the day before hospital coverage ends when the enrollee disagrees with the discharge or noncoverage decision. Prior to issuance of this notice, the MAO secures concurrence from the physician responsible for the patient's care in the hospital. The MAO's notice of non-coverage of further inpatient hospital care must include the reason why further inpatient hospital care is no longer needed; the date and time of the enrollee's liability for continued impatient care; and the enrollee's appeal rights.	PMC must develop guidelines or policy and procedures regarding how and whem the "Notice of Non-Coverge of Inpatient Hospital Care" is provided to member. This notice must include information why further inpatient hospital care is no longer needed, the date and time of the enrollee's liability for continued inpatient care, and the enrolee's appeal rights. Please ensure that this notice has been reviewed under CMS Marketing requirements in HPMS. This document must be submitted to the Regional Office along with documentation that the appropriate staff has been trained on these policies or guidelines when this notice must be provided to members. Please refer to Section 150.1 in Chapter 13 of the Medicare Managed Care Manual for guidance.	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	PMC must ensure that if it overturns it adverse organization determination denying an enrollee's request for payment, the organization will issue its reconsidered determination and send payment for the service to the enrollee or provider. This must be mailed no later than 60 calendar days from the date the plan received the request for standard reconsiderations .	Closed
Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	PMC must ensure that if it overturns it adverse organization determination denying an enrollee's request for a service, the organization will issue an authorization for the service and notify the enrollee no later than 30 calendar days from the date the plan received the request for standard reconsideration .	Closed

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Aveta, LLC.	1-787-622-3000 Ext. 5238	H4004	MA	Audit Findings	11/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	PMC must establish and maintain procedures for expediting reconsiderations. This includes establishing an efficient and convenient method for individuals to submit oral and/or written requests for expedited appeal, documenting oral requests, and maintaining said documentation in accordance with Medicare guidelines. If the MAO decides not to expedite a reconsideration request it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	Closed

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Universal American Corp.	1-713-558-4694	H3333	MA-PD	Audit Findings	11/9/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Part D sponsor must adhere to its 03/2007 Renewed Standard Operating Procedures "MPA-1 Coverage Determinations" which clearly indicates that enrollees are to be provided with verbal and/or written notification. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA-PD	Audit Findings	11/9/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Part D sponsor must submit for RO review and approval Standard Operating Procedures which clearly outline a process for providing enrollees with timely verbal and/or written notification of coverage determinations concerning payment. Part D sponsor must submit for review and approval the Standard Operating Procedures. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed

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Universal American Corp.	1-713-558-4694	H3333	MA-PD	Audit Findings	11/9/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Part D sponsor must submit for RO review and approval Standard Operating Procedures which clearly outline a process for promptly and correctly determining and informing enrollees whether a complaint is subject to its grievance procedures or its coverage determination procedures. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA-PD	Audit Findings	11/9/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Part D sponsor must adhere to its 02/22/2007 Revised Standard Operating Procedures "GA.010.01 Grievance" which clearly indicates that enrollees are to be provided with timely verbal and/or written notification. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA-PD	Audit Findings	11/9/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Part D sponsor must adhere to its 02/22/2007 Revised Standard Operating Procedures "GA.010.01 Grievance" which clearly indicates that enrollees are to be provided with verbal and/or written notification once a determination has been made. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA-PD	Audit Findings	11/9/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Part D sponsor must submit for RO review and approval Standard Operating Procedures which clearly outline a process for timely notifying and effectuating standard redeterminations concerning payment. Part D sponsor must submit for review and approval the Standard Operating Procedures. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed

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Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 05 - M+C PFFS Quality Assurance (Quality)	QAPI Program Evaluated Annually - The M+C PFFS plan must have an ongoing quality assessment and performance improvement (QAPI) program.	The corrective action plan must include the implementation of a formal process for providing oversite of the Quality Improvement Program. The corrective action plan should include (but is not limited to)Quality Assurance Committee Meetings, production of meeting notes and documentation concerning the method in which the Quality Improvement program is evaluated and information disseminated througout the organization. The Organization should develop and implement all other actions, deemed necessary, to demonstrate compliance.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Grievance Adjudication - The M+CO must adjudicate internal grievances in a manner fully consistent with the M+CO's written grievance procedure, as stated in the EOC.	The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Claim Denials (Notice Content) - If an M+CO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must develop a corrective action plan to implement the use of the standard denial notice, as provided by 42 CFR 422.568(d) and (e), and Manual Chapter 13 - Section 40.2.2. The corrective action plan must include the development and marketing submission of the standard denial notice to the Regional Office for approval as well as training concerning appropriate completion of the form. The corrective action plan must also include internal auditing, the correction of any policies and procedures and all other actions deemed necessary to demonstrate compliance.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Standard Pre-Service Denials (Timeliness) - If the M+CO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The MAO must submit to RO for review and approval its ¿Notice of Denial of Medical Coverage¿ template and ALL other enrollee notice templates relative to this element. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Standard Pre-Service Denials (Notice Content) - If the M+CO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO must submit to RO for review and approval its ¿Notice of Denial of Medical Coverage¿ template and ALL other enrollee notice templates relative to this element. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Organization Determination Extensions (Notice Content) - If an extension is taken on an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	The MAO must submit to RO for review and approval its ¿Notice of Organization Determination Extension¿ template and ALL other enrollee notice templates relative to this element. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed

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Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Decision Not to Expedite an Organization Determination (Notice Content) - If the M+CO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the M+CO will process the request using the 14-day standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the M+CO grievance process and its timeframes	The MAO must submit to RO for review and approval its ¿Notice Not to Expedite an Organization Determination¿ template and ALL other enrollee notice templates relative to this element. The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Standard Pre-Service Approvals (Timeliness) – (if applicable) - If the M+CO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Claims)	Favorable Claims Reconsiderations (Timeliness) - If the M+CO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed
Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Claims)	Adverse Claims Reconsiderations (Timeliness) - If the M+CO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS's independent review entity no later than 60 calendar days after receiving the reconsideration request. The M+CO concurrently notifies the member that it has forwarded the case to CMS's independent review entity	The corrective action plan must include training, internal auditing, correction of any policy and procedures (including determination of good cause for late filings of an appeal) and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed

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Universal American Corp.	1-713-558-4694	H3333	MA	Audit Findings	11/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Claims)	Effectuation of Third Party Claims Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must pay the claim under dispute no later than 60 days from the date it received notice of the reversal.	The corrective action plan must include training, internal auditing, correction of any policy and procedures and all other actions deemed necessary to demonstrate compliance. The corrective action plan must also include timeframes for providing the Regional Office with evidence of training as well as audit reports.	Closed
Blue Cross and Blue Shield of Florida	1-850-383-3472	H5938	MA-PD	Audit Findings	11/8/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Capital Health Plan must ensure that enrollees receive timely notices on coverage determinations either from Capital's PBM or directly by the plan itself. Please submit a policy which will specify which entity is responsible for this function, and how the plan will exercise oversight to assure implementation of timely notification.	Closed

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Blue Cross and Blue Shield of Florida	1-850-383-3472	H5938	MA	Audit Findings	11/8/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	CHP must obtain proof that the physician without malpractice insurance has established and maintained an escrow account consisting of cash or assets eligible for deposit in accordance with Title XXXII, Chapter 458, Section 458.320(a), or obtained and maintained an unexpired, irrevocable letter of credit in with Title XXXII, Chapter 458, Section 458.320(c) of Florida State law. Submit a copy to CMS. In the event the physician is unable to provide the alternative evidence, CHP needs to remove the physician from their network. CHP needs to review the existing credentialing to determine whether other providers do not maintain malpractice insure or the alternatives allowed by law. If other providers are identified, CHP must follow the procedure outlined above. Submit a plan for review the existing files along with a timeline for accomplishment to CMS. Submit a plan, including a timeline to assure the vendor uses primary source verification for credentialing and recredentialing in lieu of verifying licensure through their data warehouse and indicate how CHP will monitor vendor files to assure compliance. Indicate the person responsible for verifying compliance. Submit a plan, include timelines and the responsible department/person, indicating how CHP will incorporate quality information prior to recredentialing and indicate how CHP will assure compliance.	Closed
Blue Cross and Blue Shield of Florida	1-850-383-3472	H5938	MA	Audit Findings	11/8/2007	Closed	Chapter 06 - Provider Relations	Discrimination Against Health Care Professionals ProhibitedAn MAO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.	CHP needs to modify their policy to include the missing language and notify their providers of the change. Submit a copy of the revised policy and a copy of the notification sent to the providers to CMS.	Closed
Blue Cross and Blue Shield of Florida	1-850-383-3472	H5938	MA	Audit Findings	11/8/2007	Closed	Chapter 06 - Provider Relations	No Prohibition on Health Care Professional Advice to PatientsAn MAO may not prohibit a health care professional from advising or advocating on behalf of a patient.	CHP needs to develop a policy, contract addendum or other vehicle that addresses the specific language outlined in this element and notify providers. Submit a copy of the policies, procedures or other vehicle used to meet this element along with the notification sent to providers to CMS.	Closed
Blue Cross and Blue Shield of Florida	1-850-383-3472	H5938	MA	Audit Findings	11/8/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Capital Health Plan should ensure that its staff is properly trained to recognize the difference between a grievance and appeal. It is noted that the same Capital staff process grievances for both commercial and Medicare product lines. Refresher training should be sceduled which would highlight the difference between the definitions of grievances for the respective product lines.	Closed
Blue Cross and Blue Shield of Florida	1-850-383-3472	H5938	MA	Audit Findings	11/8/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Capital Health Plan must ensure that appeals are properly distinguished from grievances and that the appropriate appeal rights are communicated to enrollees. As noted, in the CAR for GV01, Capital should arrange for staff to have refresher training in this area.	Closed

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UnitedHealth Group, Inc.	1-412-858-4319	H3920	MA	Audit Findings	11/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	CMS requires that Unison process within the defined number of calendar days regardless of whether or not the last calendar day falls on a non-work day. CMS expects Unison to modify its procedures such that work is processed within the stated number of calendar days. CMS needs to see a copy of adjusted procedures and attestation that this policy is properly executed.	Closed
UnitedHealth Group, Inc.	1-412-858-4319	H3920	MA	Audit Findings	11/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	Unison needs to review, enlarge and improve its definitions as to why Unison is denying the claim. There are various software packages that present the information in readable formats. Unison may have to enlarge the field in which the information is displayed. CMS will want to see a plan of how Unison will define more meaningful descriptions and solve this issue. CMS expects an implementation plan as to how Unison will resolve the issue. Once Unison executes the plan, we want a copy of the new categories.	Closed
UnitedHealth Group, Inc.	1-412-858-4319	H3920	MA	Audit Findings	11/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Enlarge the field used to describe the reason for the denial. Prepare, or purchase, a list of more meaningful descriptors that can be entered into the field as the reason for denial. CMS will want to see a plan of how Unison will solve this issue. Once issue has been solved and new descriptors assigned, CMS will pull a random sample of cases for review.	Closed
UnitedHealth Group, Inc.	1-412-858-4319	H3920	MA	Audit Findings	11/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	1) CMS requires that Unison process within the defined number of calendar days regardless of whether or not the last calendar day falls on a non-work day. CMS expects Unison to modify its procedures such that work must be processed within the stated number of calendar days. CMS needs to see a copy of adjusted procedures and attestation that this policy is properly executed. 2) CMS expects Unison to develop a plan, policy and procedure such that every case that is denied, Unison can ensure that every person has been notified via letter of the person's appeal rights.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-412-858-4319	H3920	MA	Audit Findings	11/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	CMS requires that Unison process within the defined number of calendar days regardless of whether or not the last calendar day falls on a non-work day. CMS expects Unison to modify its procedures such that work must be processed within the stated number of calendar days. CMS needs to see a copy of adjusted procedures and attestation that this policy is properly executed.	Closed
UnitedHealth Group, Inc.	1-412-858-4319	H3920	MA	Audit Findings	11/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	Unison needs to review, enlarge and improve its definitions as to why Unison is denying the claim. There are various software packages that present the information in readable formats. Unison may have to enlarge the field in which the information is displayed. We expect to see the plan for correcting this deficiency. Once the plan is executed, we expect to see a list of the new descriptions.	Closed

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UnitedHealth Group, Inc.	1-412-858-4319	H3920	MA	Audit Findings	11/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	CMS requires that Unison process within the defined number of calendar days regardless of whether or not the last calendar day falls on a non-work day. CMS expects Unison to modify its procedures such that work must be processed within the stated number of calendar days. CMS needs to see a copy of adjusted procedures and attestation that this policy is properly executed.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	ATRIO Health Plan did not meet the documentation requirements regarding notifying prescribers, network pharmacies, and pharmacists of negative formulary changes. AHP must (1) develop and implement and submit to CMS policies and procedures that include provisions (a) to notify prescribers, network pharmacies, and pharmacists of negative formulary changes at least 60 days prior to the date the change becomes effective, (b) to provide retrospective notice of formulary changes to authorized prescribers, network pharmacies, and pharmacists if a drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, and (c) that describes the method used to provide notification of these formulary changes on its website, (2) submit to CMS documentation demonstrating that its website is providing timely notification, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	ATRIO Health Plan did not meet the documentation requirements to maintain a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. AHP (1) must submit documentation to CMS on Samples 2, 7, and 8 that verifies the rapid disenrollment clause, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	ATRIO Health Plan did not meet the requirement to provide a written notice to affected enrollees at least 60 days prior to the date that a covered Part D drug is removed from its formulary, or before making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. AHP must (1) develop and implement and submit to CMS policies and procedures to include provisions to provide direct written notice to affected enrollees (currently taking the affected drug) at least 60 days prior to the date the change becomes effective or provide such enrollee with a 60-day supply of the drug under the same terms as previously allowed and provide written notice of the formulary change at the time an affected enrollee requests a refill of the drug with a discussion of the format to be used, (2) include a provision to address retrospective notice when a drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	ATRIO Health Plan did not meet the requirement regarding access to long-term care pharmacies. AHP must (1) develop and implement policies and procedures stating that the AHP must offer standard contracting terms and conditions, including performance and service criteria to any willing LTC pharmacy in its service area, (2) provide instructions and training for any delegates responsible for this requirements and ensure that delegate¿s policies and procedures include this provision, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	ATRIO Health Plan did not meet the requirements regarding the process for providing a notice of ¿maintenance¿ formulary changes to CMS and entities providing other prescription drug coverage. AHP must (1) develop and implement and submit to CMS policies and procedures that include provisions (a) addressing notice of ¿maintenance¿ formulary changes to CMS and entities providing other drug coverage, in accordance with CMS requirements, (b) addressing notice of ¿other¿ formulary changes to CMS and entities providing other drug coverage, in accordance with CMS requirements, (c) addressing procedures used to provide retrospective notice to CMS and entities providing other drug coverage when drugs are immediately removed from the formulary because they are deemed unsafe by the FDA or removed from the market by the manufacturer, and (d) describing the method used to provide notification of formulary changes, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	ATRIO Health Plan did not meet the requirement to have an appropriate transition process for residents of long-term care facilities. AHP must (1) correct and implement policies and procedures to include provisions (a) to provide a temporary supply of non-formulary Part D drugs, including Part D drugs that are on its formulary but require prior authorization or step therapy under an its utilization management rules, for a new enrollee in a LTC facility for up to 31 days (unless the prescription is written for less than 31 days), (b) to honor multiple fills of non-formulary Part D drugs for up to 90 days of enrollees¿ coverage in the new AHP, (c) provide an emergency supply of non-formulary drugs, including Part D drugs that require prior authorization or step therapy under its utilization management rules, for current enrollees entering a LTC setting from other care settings, and (d)to the extent that an enrollee in a LTC setting is outside his or her 90-day transition period, to provide an emergency supply of non-formulary Part D drugs, while an exception is being processed for current enrollees in a LTC setting. Emergency supplies of non-formulary Part D drugs must be for at least 31 days of medication, unless the prescription is written for less than 31 days, (2) provide CMS with a system report on its transition process utilization for LTC residents for three consecutive months or until CMS requirements are reached and sustained, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	ATRIO Health Plan did not meet the requirement to post appropriate coverage determination or exception notices in network pharmacies: AHP must (1) develop and implement policies and procedures that include provisions (a) for arranging with its network pharmacies to post or distribute the ¿Medicare Prescription Drug Coverage and Your Rights¿ notice instructing enrollees to contact their AHPs to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist, (b) for sending the ¿Medicare Prescription Drug Coverage and Your Rights¿ notice to the location in the LTC facility designated to accept such notices or if the network or preferred pharmacy is on-site, it must deliver the notice to the location in the LTC facility designated to accept such notices, (2) demonstrate that it monitors network pharmacies to ensure that they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception, (3) receive monitoring reports on posting and distributing these notices and provide documentation to CMS, (4) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (5) for each of the prior four tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	ATRIO Health Plan did not meet this requirement to maintain policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations. AHP must (1) develop and implement policies and procedures that include provisions (a) for tracking and addressing the timely review and resolution of all enrollee requests for coverage determination (both expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug, and a provision, and (b) for tracking and addressing the timely review and resolution of all enrollee requests for redeterminations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ), (2) provide CMS with the AHP¿s tracking log for all coverage determinations, redeterminations, reconsiderations by the IRE, and reviews by the ALJ, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	ATRIO Health Plan did not meet the requirement to provide timely notification of coverage determinations concerning the drug benefit. AHP must (1) develop and implement policies and procedures that include a provision stating that if a coverage determination is denied and the initial notification is provided orally, the AHP must send written notice within 3-calendar days of the oral notice and that require the use of a CMS approved notice, (2) provide documentation to CMS demonstrating compliance with the notice requirement, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expect to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	ATRIO Health Plan did not meet the requirement to establish and maintain timely notification of coverage determinations concerning payment. AHP must (1) develop policies and procedures to ensure that approved notices are sent to enrollees within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	ATRIO Health Plan did not meet the requirement to provide approved language and written notification regarding enrollee notification of adverse coverage determinations. AHP must (1) revise its policies and procedures to include the provisions that (a) the AHP will send a written notice to the enrollee or it¿s identified appointed representative of an adverse coverage determination, and (b) if the enrollee¿s physician files a request on behalf of the enrollee, and the AHP did not notify the prescribing physician of an adverse determination orally, the AHP must provide written notice to the enrollee and the enrollee¿s prescribing physician, (2) provide documentation demonstrating that the AHP provides enrollees with an approved CMS notice, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	ATRIO Health Plan did not meet the requirement that a Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination. AHP must (1) revise its policies and procedures to include the provisions that (a) all oral requests must be documented in writing and that documentation of the request must be retained in the case file, and (b) describe its process for handling and receiving expedited coverage determinations outside normal business hours, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	ATRIO Health Plan did not meet the requirement for timely notification following a decision to deny a request for an expedited coverage determination. AHP must (1) revise its policies and procedures to include provisions (a) to ensure that enrollees are notified of its decision to deny a request for expedited coverage determination in accordance with CMS requirements, and (b) that if it denies a request to expedite a coverage determination, will automatically transfer the request for processing under the standard coverage determination timeframe, and that the enrollee and the prescribing physician, if involved, are given prompt oral notice of denial, and a written notice is mailed to the enrollee, within three calendar days. (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	ATRIO Health Plan did not meet the notice content requirements for enrollee notification following the decision to deny a request for an expedited coverage determination. AHP must (1) revise its policies and procedures to include the provisions that oral and written notices must (a) provide an explanation that the AHP must process the request using the 72-hour timeframe for standard determinations, inform the enrollee of the right to file an expedited grievance, (b) inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support, and (c) provide instructions about the AHP¿s grievance process and its timeframes, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained , and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	ATRIO Health Plan did not meet the documentation requirements for timely notification of expedited coverage determinations. AHP must (1) revise its policies and procedures to include the provisions that (a) AHP must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, after receiving the physician¿s supporting statement, (b) failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the AHP to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and (c) AHP must inform the enrollee within 24 hours, when the case is forwarded to the IRE, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	ATRIO Health Plan did not meet the notice content requirements for expedited coverage determinations. AHP must (1) revise its policies and procedures to include the provisions that (a) if the decision is adverse, then the AHP must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and (b) if oral notice is provided for adverse decisions, the notices must satisfy the following requirements (states the specific reason for the denial and takes into account the enrollee¿s medical condition, disabilities, and special language requirements, if any, provides information regarding the right to appoint a representative to file an appeal on the enrollee¿s behalf, and provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeal process), (2) provide CMS with a CMS-approved notice, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	ATRIO Health Plan did not meet the requirement to establish and maintain reasonable and complete exceptions procedures for a tiered cost-sharing structure. AHP must (1) revise its policies and procedures to include provisions that (a) if the AHP requires a written statement from the enrollee¿s prescribing physician that the prescribing physician is required to demonstrate in the statement why the exception is needed (would not be as effective as the requested drug and/or would have adverse effects), it must do so immediately, (b) if the AHP makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, (c) it must not keep the exception request open indefinitely when a physician does not submit a supporting documentation, and (d) if the AHP is waiting on physician¿s statement in support of a tiering exception request, it must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	ATRIO Health Plan did not meet the requirement to establish and maintain exceptions procedures for non-formulary drugs. AHP must (1) revise its policies and procedures to include the provisions that the prescribing physician statement must indicate that the requested drug is medically required and other non-formulary drugs and dosage limits would not be effective if, (i) all covered drugs on any tier would not be as effective as the non-formulary drug and/or would have adverse effects, (ii) the number of doses has been ineffective or based on sound clinical evidence, the drug regimen is likely to be ineffective or adversely affect the drugs effectiveness or patient compliance, (iii) the drug alternative listed on the formulary or required to be used in step therapy has been ineffective or has caused an adverse reaction, (2) a request for additional supporting documentation must clearly identify the type of information required from the physician, (3) AHP must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception, and (4) AHP must grant a formulary exception when it determines that one of the three factors above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug, and (5) provide documentation demonstrating the requirement for notice template for requesting additional information from the enrollee¿s prescribing physician, (6) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (7) for each of the prior tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	ATRIO Health Plan did not meet the requirement for approval of tiering and non-formulary exception requests. AHP must (1) revise its policies and procedures to include a provision that enrollees are not required to request an approval following the initial prescription for the remainder of the year, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	ATRIO Health Plan (AHP) did not meet the requirement to correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures. AHP must (1) develop a process to ensure that it provides enrollees with a CMS-approved Notice of Inquiry Regarding an Excluded Drug, (2) develop a process to ensure that it correctly determines and informs enrollees as to whether or not a complaint is subject to its grievance or coverage determination procedures, (3) revise its grievance policies and procedures to include the correct definition of a Part D grievance, (4) submit to CMS all revised and newly developed grievance policies and procedures related to this deficiency, (5) conduct training of appropriate staff on these policies and procedures, (6) submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (7) for each of the prior tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	ATRIO Health Plan did not meet the requirements to establish and maintain policies and procedures for tracking and addressing timely hearing and resolution of oral and written enrollee grievances. AHP must (1) revise its policies and procedures to include (a) a process to ensure timely and appropriate grievance resolution proceedings, and (b) a process for full investigation of grievance when necessary, (2) develop a process to track and maintain the date of receipt and the date that the enrollee was notified of the disposition of the grievances (3) develop a process to ensure timely and accurate Part D quarterly reporting, (4) submit to CMS all revised or newly developed grievance policies and procedures related to this deficiency, (5)conduct training of appropriate staff on these policies and procedures, (6) submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (7) for each of the prior six tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	ATRIO Health Plan did not meet the requirement to train relevant staff or delegates on the Part D sponsor¿s grievance policies and procedures. AHP must (1) develop and implement Part D training for all of staff and delegates that are responsible for its Part D administration, and (2) submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	ATRIO Health Plan did not meet the requirement to notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but not later than 30 days after the date the Part D sponsor receives the oral or written grievance. AHP must (1) revise its policies and procedures to include provisions (a) to notify all concerned parties of the grievance disposition as expeditiously as the enrollee¿s case requires based on the enrollee health status but not later than 30 days after the AHP receives the oral or written grievance, (b) that provide appropriate explanations and timeframes for extensions related to grievances, and (c) that explain the justification for the request for additional information and how the delay is in the interest of the enrollee, (d) that include a process to immediately notify enrollees in writing when the AHP extends a grievance deadline, and (e) that include a process to provide enrollees with a CMS-approved Notice, (2) provide CMS documentation demonstrating a compliant notice, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	ATRIO Health Plan did not meet the requirement to respond to all written grievances in writing, including facsimile. AHP must (1) revise its grievance policies and procedures to include the provisions that (a) all categories of grievances submitted in writing must be responded to in writing, and (b) grievances submitted orally are responded to either orally or in writing, unless the enrollee requests a written response, (2) provide documentation to CMS demonstrating that it notifies enrollees of all categories of grievance resolution in a timely and consistent manner, (3) develop a process to ensure that it uses CMS approved notices to notify enrollees, (4) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained, and (5) for each of the prior four tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	ATRIO Health Plan did not meet the requirement to respond in writing to all grievances related to the quality of care. AHP must (1) develop policies and procedures that include provisions that (a) states AHP¿s commitment to work with the QIO in resolving grievance cases, (b) include a description of the enrollee¿s right to file a written complaint with the QIO, (c) include a provision to only use CMS-approved notices to notify Medicare enrollees, (2) provide revised policies and procedures for these deficiencies to CMS, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	ATRIO Health Plan did not meet the requirement to respond to an enrollee¿s expedited grievance within 24 hours. AHP must (1) revise its policies and procedures to include a provision stating the AHP must respond within 24 hours to the enrollee¿s expedited grievance if the complaint involves a refusal by the AHP to grant an enrollee¿s request for an expedited coverage determination, or an expedited redetermination, and the enrollee has not yet purchased the drug that is in dispute, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	ATRIO Health Plan did not meet the requirement to have policies, procedures, and systems that allows it to accept written requests for standard redeterminations of coverage determinations filed within 60-calendar days of the notice of the coverage determination. AHP must (1) revise its policies and procedures to include provisions for accepting written requests for standard Part D determinations, and for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	ATRIO Health Plan did not meet the requirement to establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. AHP must (1) revise its policies and procedures to include provisions (a) for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, (b) to include the name of a designated office and or department to receive both oral or written requests and a telephone number for oral requests, (c) for documenting all oral requests in writing, (d) for maintaining documentation of expedited redetermination requests in a case file, (2) demonstrate its system of accepting oral and written requests for expedited redeterminations by providing an expedited redetermination log or a systems report, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	ATRIO Health Plan did not meet the requirements for promptly deciding whether to accept or deny requests for expedited redeterminations. AHP must (1) revise its policies and procedures to include the provisions that (a) the decision to accept or deny an expedited redetermination request is based on the fact that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function, (b) AHP automatically expedites a request when the enrollee¿s physician indicates that applying the standard timeframe may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function, and (c) any additional medical information the AHP requires must be requested within 24 hours of receiving the initial expedited request, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	ATRIO Health Plan did not meet the documentation requirement for timely notification and effectuation of standard redetermination concerning covered drug benefits. AHP must (1) revise its policies and procedures to include provisions (a) for effectuating favorable redeterminations as expeditiously as the enrollee¿s health requires or within 7 calendar days from the date it received the request for a standard redetermination, (b) stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring the AHP to forward the enrollee¿s complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, (c) stating the AHP must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, and (d) use a notice consistent with CMS-issued model notice, (2) provide documentation of the notice to CMS, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	ATRIO Health Plan did not meet the documentation requirement for timely notification and effectuation of standard redeterminations concerning payment. AHP must (1) revise its policies and procedures to include the provisions that (a) for favorable redeterminations to the enrollee (concerning payment), the AHP must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, (b) failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the AHP to forward the enrollee¿s complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and (c) that it must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, (2) submit documentation demonstrating , including policies and procedures,that it provides enrollees with a notice consistent with CMS-issued model notice, Request for Reconsideration, notice template for notifying enrollees of an adverse standard determination, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	ATRIO Health Plan did not meet the documentation requirement for timely notification of expedited redeterminations and requests for medical information. AHP must (1) revise its policies and procedures to include the provisions that (a) the AHP must notify the enrollee (and the prescribing physician involved, as appropriate) of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after it received the request for an expedited redetermination, (b) notification of a favorable decision may be made orally or in writing, (c) an initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, (d) any request for medical information must be requested within 24 hours of the enrollee¿s initial request, (e) failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the AHP to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and (f) the AHP must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, (2) submit documentation demonstrating, including policies and procedures, that AHP provides enrollees with a notice consistent with CMS-issued model notice, Request for Reconsideration, and notice consistent with CMS-issued model, Notice of Right to an Expedited Grievance when appropriate, (3) conduct training on these policies and procedures and submit documentation to CMS that details the nature of this training, including materials used in the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	ATRIO Health Plan must meet the requirement for expedited coverage redetermination reversals. AHP must (1) revise its policies and procedures to include a provision for authorizing or providing the benefits in dispute within a 72-hour required timeframe, (2) provide documentation demonstrating its systems for authorizing or providing benefits under dispute within 72 hours of receiving request for redetermination for expedited coverage determination reversals, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	ATRIO Health Plan did not meet the documentation requirement for review of adverse coverage determination. AHP must (1) revise its policies and procedures to include provisions stating that (a) a person(s) who were not involved in making the coverage determination conducts the redetermination, and (b) if the issue is a denial based on lack of medical necessity then it must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the service at issue, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	ATRIO Health Plan did not meet the documentation requirement for timely transfer to the Independent Review Entity (IRE) upon a reconsideration request. AHP must (1) revise and submit to CMS its policies and procedures to include (a) a provision that case files must be sent to the IRE within 24 hours for expedited requests or 48 hours for standard requests from the time the IRE requests the case file, and (b) a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number, (2) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (3) for each of the prior two tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	ATRIO Health Plan did not meet the documentation requirement for effectuating third party reversals on an appeal of a request for a benefit. AHP must (1) revise and submit to CMS ¡ ts policies and procedure requiring that a notice be sent to the IRE informing them of the effectuation, (2) submit documentation demonstrating that it provides the IRE with a notice consistent with CMS-issued model notice, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	ATRIO Health Plan did not meet the requirements for effectuation of third party reversals on an appeal for request of payment. AHP must (1) revise and submit to CMS its policies and procedures for effectuating third party reversals on an appeal of a request for payment to include the provisions that (a) payment must be authorized within 72 hours from the date it receives notice reversing the decision, and (b) payment must be made no later than 30 days from the date of decision, (2) provide documentation of the approved notice informing the IRE of effectuation of its decision, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA-PD	Audit Findings	11/2/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	ATRIO Health Plan did not meet the requirements for effectuating third party reversals on an appeal of an expedited request for a benefit. AHP must (1) revise and submit its policies and procedures to include the provisions that (a) a benefit under dispute must be authorized or provided as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the decision, and (b) a notice must be sent informing the IRE of the effectuation, (2) the AHP must provide documentation demonstrating a notice informing the Independent Review Entity (IRE) of the effectuation of decision, (3) conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained, and (4) for each of the prior three tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	ATRIO Health Plan must (1) develop an appropriate Medicare Advantage Utilization (UM) Program that meets CMS requirements. At a minimum,the UM program must include written policies a procedures that reflect Medicare coverage guidelines and National coverage determinations and local medical review polices, (2) develop a formalized process to conduct clinical peers review decisions to deny authorization on grounds of medical appropriateness in a consistent manner, (3) develop policies and procedures that clearly reflect Medicare coverage rules (national coverage decisions and local medical review policies) or formally adopt practice guidelines that are appropriate for Medicare enrollees. Where there are variations between coverage determinations for Special Needs Medicare Advantage enrollees (SNP), ATRIO Health Plan must clearly state and explain variations in all UM policies and procedures, (4) ensure that the UM criteria are reviewed and approved by a committee of professionals that include practicing and participating providers,(5) communicate practice guidelines and UM criteria to providers through newsletter articles, provider educational trainings, and provider manuals, (6) established an inter-rater reliability process in order to verify that reviews are made consistently and in accordance with established criteria, (7) ensure UM policies and procedures for its Medicare Advantage enrollees include explicit time frames for completing and communicating UM decisions to enrollees and providers, (8) develop case management activities, (9) ensure UM activities do not provide incentives to deny, limit, or discontinue Medicare services, (10) train appropriate staff on UM policies and procedures, (11) provide the Seattle Regional Office (RO) with documentation of the training, the name and position of each staff member that received UM training, staff that conducted training, and details regarding the nature of the training, including the materials used in the training, and (12) for each of the prior eleven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 05 - Quality Assurance	Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).	A call was held on October 31 with CMS Region X, Atrio, and the MAQRO to discuss the review findings and the CAR/CAP. A summary of the recommendations and CAR is provided. Atrio should submit a workplan and timeline to address the CCIP deficiencies within 90 days. The specific areas that should be addressed include: *Development of a comprehensive program description and accompanying policies and procedures. *Process to contact, inform,and screen or risk stratify eligible members *Interventions to improve care coordination and health status, including staff and roles, and how services are integrated and organized between external and internal staff, and how members at high risk are pro-actively identified by the MAO for more intensive services. *Periodic monitoring of individual CCIP participants and tracking of individual status or outcomes *Quantitative measures of improvement including specific measures and data sources and data collection. Some additional recommendations for improvement are made in the full review report.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 05 - Quality Assurance	Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.	A call was held on October 31 with CMS Region X, Atrio, and the MAQRO to discuss the review findings and the CAR/CAP. A summary of the recommendations and CAR is provided: Atrio should seek available training opportunities for QIP conduct. Resources include: ICE Conference, December 2007, CMS Quality and Compliance Conference, April 2008, as well as the QIP Tools and Guides which will be posted to the CMS Health Plans page. 2006 QIP - Flu Vaccinations In order to meet CMS requirements, Atrio should revise its measurements periods as: baseline - 2005 flu season, re-measurement - 2006 flu season. In order that the measurements are comparable, Atrio should report the 2006 rates calculated both using claims sources only (comparable to 2005 rate) and using all data sources (comparable to future measurements). Atrio should submit a revised QIP report, reflecting the changes, within 90 days. Atrio is also advised to conduct a second re-measurement for the 2007 flu season period. 2007 QIP - Pneumonia Vaccinations In order to meet CMS requirements, Atrio may conduct a project on pneumonia vaccination for its 2007 QIP. Atrio should revise its indicator, and use the CAHPS pneumonia vaccination question as the project indicator, as it will be very difficult to re-formulate the current indicator and methodology. Atrio should submit a revised QIP report, reflecting the changes, within 90 days. For both 2006 and 2007 QIP Additional recommendations for improvement to already compliant processes regarding topic selection, performance targets, and data validity and reliability are provided in the full review reports.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	ATRIO Health Plan must: 1) Amend its contracts with the Independent Physicians Associations to specify activities delegated, reporting requirements and remedies. (See elements CN02, CN04 and CN6) 2) Establish and maintain effective oversight of the MAO¿s delegated entities to ensure there is a documented process for initial credentialing and re-credentialing that complies with Medicare credentialing requirements. Include a workflow diagram with timelines. 3) Provide the Regional Office (RO) a copy of the MAO¿s approved credentialing/re-credentialing policy and procedure utilized by the MAO and delegated entities. 4) Ensure its delegated entities include Quality of Care complaints collected through the MAO¿s Quality Improvement (QI) Program in the re-credentialing process, as documented by the MAO¿s policies and procedures. 5) Ensure the delegated entities review the most current Medicare/Medicaid Sanction list, and Medicare Opt Out list in the delegated process. 6) Develop and implement an internal audit process to ensure the credentialing/re-credentialing process comply with Medicare requirements. 7) Provide the Regional Office (RO) with a detailed summary report outlining the MAO¿s audit findings, and corrective action plan. The report should include the title of the auditor(s), the audit methodology, and the results of the audit. 7) For each of the seven tasks of this Corrective Action Request, clearly state in the MAO¿s Corrective Action Plan when the MAO will complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 11 - Contracts	Required Contract Provision: Prompt PaymentThe MAO's written contracts with first tier and downstream entities must contain a prompt payment provision.	ATRIO Health Plan must: 1) Establish and maintain effective oversight of the MAO¿s internal and delegated entities contracting process to ensure direct, downstream and administrative contracts contain the prompt payment provision. 2) Develop and implement a consistent, documented contracting process for direct, downstream and administrative contracts, to include a workflow diagram with timelines. 3) Develop policies and procedures outlining how the MAO will monitor contract compliance for direct, downstream and delegated entity contracting. 4) Develop and implement an internal audit process to ensure contracts comply with Medicare requirements. 5) Provide the Regional Office (RO) with a detailed summary report outlining the MAO¿s audit findings, and corrective action plan. The report should include the title of the auditor(s), the audit methodology, and the results of the audit. 6) Amend direct, downstream and administrative contracts that do not comply with the required Medicare contract provisions. 7) For each of the six tasks of this Corrective Action Request, clearly state in the MAO¿s Corrective Action Plan when the MAO will complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	ATRIO Health Plan must: 1) Establish and maintain effective oversight of the MAO¿s internal and delegated entities contracting process to ensure direct, downstream and administrative contracts contain the provision to maintain records for a minimum of 10 years. 2) Develop and implement a consistent, documented contracting process for direct, downstream and administrative contracts, to include a workflow diagram with timelines. 3) Develop policies and procedures outlining how the MAO will monitor contract compliance for direct, downstream and delegated entity contracting. 4) Develop and implement an internal audit process to ensure contracts comply with Medicare requirements. 5) Provide the Regional Office (RO) with a detailed summary report outlining the MAO¿s audit findings, and corrective action plan. The report should include the title of the auditor(s), the audit methodology, and the results of the audit. 6) Amend direct, downstream and administrative contracts that do not comply with the required Medicare contract provisions. 7) For each of the six tasks of this Corrective Action Request, clearly state in the MAO¿s Corrective Action Plan when the MAO will complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.	ATRIO Health Plan must: 1) Establish and maintain effective oversight of the MAO¿s internal and delegated entities contracting process to ensure direct, downstream and administrative contracts contain the provision to comply with the MAO¿s policies and procedures. 2) Develop and implement a consistent, documented contracting process for direct, downstream and administrative contracts, to include a workflow diagram with timelines. 3) Develop policies and procedures outlining how the MAO will monitor contract compliance for direct, downstream and delegated entity contracting. 4) Develop and implement an internal audit process to ensure contracts comply with Medicare requirements. 5) Provide the Regional Office (RO) with a detailed summary report outlining the MAO¿s audit findings, and corrective action plan. The report should include the title of the auditor(s), the audit methodology, and the results of the audit. 6) Amend direct, downstream and administrative contracts that do not comply with the required Medicare contract provisions. 7) For each of the six tasks of this Corrective Action Request, clearly state in the MAO¿s Corrective Action Plan when the MAO will complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	ATRIO Health Plan must: 1) Submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. 2) Develop grievance polices and procedures that allows the organization to differentiate between Part C grievances and Part D grievances. Polices and procedures must clearly map the workflow of grievance staff, including the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 3) Develop efficient oversight and management of grievance responsibilities by appropriate and consistent documentation of grievances, to include: quality of care complaints, appropriately tracking all grievances, and the ability to accurately distinguish a grievance from an appeal.. 4) Develop processes to ensure grievances are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 5) For each of the four tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.	Closed

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ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	ATRIO Health Plan must: 1) Submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. 2) Develop grievance polices and procedures that allows the organization to differentiate between Part C grievances and Part D grievances. Polices and procedures must clearly map the workflow of grievance staff, including the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 3) Develop efficient oversight and management of grievance responsibilities by appropriate and consistent documentation of grievances, to include: quality of care complaints, appropriately tracking all grievances, and the ability to accurately distinguish a grievance from an appeal.. 4) Develop processes to ensure grievances are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 5) For each of the four tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	ATRIO Health Plan must: 1) Submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. 2) Develop grievance polices and procedures that allows the organization to differentiate between Part C grievances and Part D grievances. Polices and procedures must clearly map the workflow of grievance staff, including the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 3) Develop efficient oversight and management of grievance responsibilities by appropriate and consistent documentation of grievances, to include: quality of care complaints, appropriately tracking all grievances, and the ability to accurately distinguish a grievance from an appeal.. 4) Develop processes to ensure grievances are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 5) For each of the four tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	ATRIO Health Plan must achieve and maintain effective oversight of correct claim determinations, which include developing the claim for additional information. ATRIO Health Plan must (1)develop and implement policies and procedures (a)requiring its staff and delegated entities to develop claims for the necessary information needed in order to make a correct claim determination, (b)that require staff with the appropriate professional level to review development information and make a claim determination, (c)describing when authorizations are required, (d)describing its claim timeliness guidelines, (e)instructing staff and delegated entities to fully document all claim development and, (f)describing its oversight plan for continued monitoring of its delegated entities, (2)train appropriate staff and delegated entities on the policies and procedures, (3)provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4)conduct internal audits of denied claim determinations. The audits must evaluate whether denied claims were developed when additional information was required to make a claim determination, what professional level of staff reviewed the documentation and made a claim determination, whether the development was fully documented and if Medicare guidelines and MAO policies and procedures were evaluated in the coverage decision, (5)provide the RO with a mock-up report that demonstrates how it will report on its progress and monitoring of its processes, (6)provide a summary report to the RO every month until further notified, and (7)for each of the prior six tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	ATRIO Health Plan must achieve and maintain effective oversight of correct claim payments for non-contracted providers, which include developing written documentation of its payment mechanisms. ATRIO Health Plan must (1)develop and implement policies and procedures that document how it uses Medicare fee-for-service schedules, Groupers and Pricers to pay non-contracted provider claims of all types, (2)document its process for updating fee schedules, (3)update its Claim and Record Retention policy to reflect that records must be retained for ten years-see CN04, (4)train appropriate staff and delegated entities on the policies and procedures, (5)provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (6)conduct internal audits of non-contracted paid claims. The audits must evaluate whether the appropriate Medicare fee-for-service payment mechanisms were used in the payment of those claims, (7)provide the RO with a mock-up report that demonsrates how it will report on its progress and monitoring of its processes, (8)provide a summary report to the RO every month until further notified, and (9)for each of the prior eight tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	ATRIO Health Plan must: 1) Submit a new universe and sample case files for Reguests for Expedited Organization Determinations per the RO Plan Manager's instructions. 2) Develop efficient oversight and management of Reguests for Expedited Organization Determinations responsibilities by appropriate and consistent documentation of requests, to include: the ability to promptly determine whether to expedite an organization determination and provide appropriate and timely oral and written member notification on the determination of the requests. 3) Develop processes to ensure Reguests for Expedited Organization Determinations are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 4) For each of the three tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	ATRIO Health Plan must: 1) Submit a new universe and sample case files for Reguests for Expedited Organization Determinations per the RO Plan Manager's instructions. 2) Develop efficient oversight and management of Reguests for Expedited Organization Determinations responsibilities by appropriate and consistent documentation of requests, to include: the ability to promptly determine whether to expedite an organization determination and provide appropriate and timely oral and written member notification on the determination of the requests. 3) Develop processes to ensure Reguests for Expedited Organization Determinations are accurately categorized in the MAO¿s system and tracked until they are appropriately resolved. 4) For each of the three tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	ATRIO Health Plan must: 1) Submit a new universe and sample case files for Reguests for Expedited Organization Determinations per the RO Plan Manager's instructions. 2) Develop efficient oversight and management of Reguests for Expedited Organization Determinations responsibilities by appropriate and consistent documentation of requests, to include: develop process that allows the organization to correctly distinguish between organization determinations and reconsiderations. 4) For each of the two tasks of this Corrective Action Request, clearly state in the MAO's Corrective Action Plan when the MAO will complete the corrective action.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	ATRIO Health Plan must: 1) Submit a new universe and sample case files for Favorable Standard Pre-Service Organization Determinations per the RO Plan Manager's instructions.	Closed
ATRIO Health Plans	1-541-672-8620 Ext. 5206	H3814	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	ATRIO Health Plan must: 1) Revise its polices and procedures (including "desk guides/procedures") to ensure that when the organization makes a fully favorable decision on a standard pre-service reconsideration, a decision is issued to the member and the service is authorized no later than 30 calendar days after receiving the reconsideration request. 2) Train appropriate staff on the policies and procedures. 3) Provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training. 4) Conduct internal audits of favorable standard pre-service reconsideration request. 5) Provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit. 6) For each of the prior five tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H1850	MA	Audit Findings	11/2/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	WHP must establish a mechanism for reporting the results for all individuals tested on their understanding of the Medicare program. Per WHP policies and procedures, CMS will look to see if test results are available for each sales representative. If the test results are not available, the plan must show how each rep was trained, and track the effectiveness of the training. These results are important in determining the representatives level of understanding of the Medicare program.	Closed
Windsor Health Group	1-615-782-7804	H1850	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	Windsor Health Plan (WHP) must submit a monitoring review process which will ensure that all claims are being paid or denied properly. The monitoring review process must include, but not be limited to, the date of implementation, staff responsible for the approval of the review process, how the review process will be monitored and the frequency of the review process. WHP must develop policies and procedures (PP) for claim processing. The PPs must include the complete claim process from the receipt date by WHP to payment or denial. The PPs must be signed, approved by the appropriate WHP staff and include current Medicare Private Fee For Service regulations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H1850	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Interest on Clean Claims Paid Late - If the M+CO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and (C).	The MAO must provide training for its staff regarding element OC04. The MAO must submit a copy of the training provided along with a copy of the sign in sheet indicating who attended the training. The MAO must implement a monitoring review system or process to ensure all clean claims are being paid within 30 days to include, but not be limited to, who will conduct the monitoring, a schedule as to when the monitoring will be conducted, the frequency of the monitoring, and staff responsible for the approval of the review process. The MAO must implement a monitoring review system or process to ensure interest is paid on all clean claims not processed with in 30 days to include, but not be limited to, who will conduct the monitoring, a schedule as to when the monitoring will be conducted, the frequency of the monitoring and staff responsible for the approval of the review process. The MAO must The MAO must submit a copy of the monitoring review system or process. Windsor Health Plan must develop policies and procedures (PP) for claim processing. The PPs must include the complete claim process from the receipt date by WHP to payment or denial. The PPs must be signed, approved by the appropriate WHP staff, and include all current Medicare Private Fee For Service regulations.	Closed
Windsor Health Group	1-615-782-7804	H1850	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Claim Denials (Notice Content) - If an M+CO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	WHP must immediately start using OMB Approval No. 0938-0829 Form No. CMS-1003-NDP (June2001). WHP must submit a monitoring review system or process ensuring they have implemented the correct OMB form, The monitoring review system or process must include, but not be limited to, the date of implementation, who approved the implementation, and how the implementation will be monitored. WHP must submit a revised list of denial reasons for this product. Each denial reason must clearly state the reason the claim was denied. WHP must implement a monitoring review system to ensure the correct denial reasons are displayed on all denied claims. The monitoring review system or process must include, but not be limited to who will conduct the monitoring, a schedule with the begin date and the frequency of the monitoring. WHP must submit a corrected EOB to include the date field. Windsor Health Plan (WHP) must develop policies and procedures (PP) for claim processing. The PPs must include the complete claim process from the receipt date by WHP to payment or denial. The PPs must be signed, approved by the appropriate WHP staff, and include all current Medicare Private Fee For Service regulations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H1850	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Requests for Expedited Organization Determinations (Timeliness) - The M+CO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the M+CO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the M+CO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the M+CO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	WHP is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, WHP will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from December 2006 to May 2007. WHP should submit the Universe to CMS no later than December 17, 2007 for sample selection.	Closed
Windsor Health Group	1-615-782-7804	H1850	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Expedited Denials (Notice Content) - If the M+CO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	WHP is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, WHP will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from December 2006 to May 2007. WHP should submit the Universe to CMS no later than December 17, 2007 for sample selection.	Closed
Windsor Health Group	1-615-782-7804	H1850	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Pre-Service)	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The M+CO must correctly distinguish between organization determinations and reconsiderations.	WHP is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, WHP will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from December 2006 to May 2007. WHP should submit the Universe to CMS no later than December 17, 2007 for sample selection.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	WHP must establish a mechanism for reporting the results for all individuals tested on their understanding of the Medicare program. Per WHP policies and procedures, CMS will look to see if test results are available for each sales representative. If the test results are not available, the plan must show how each rep was trained, and track the effectiveness of the training. These results are important in determining the representatives level of understanding of the Medicare program.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 06 - Provider Relations	Participation and Termination Procedures - The MAO must have written policies and procedures and a process for rules of physician participation and adverse participation decisions.	Revise/develop policies and procedures to include quality control measures for timely collection of credentialing applications subsequent to the execution of provider contracts. Incorporate timely processing requirements for credentialing of the applications. Submit an approved and signed copy to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	The MAO identified its credentialing deficiencies and implemented an internal corrective action plan. CMS is requesting the following additional corrective action: The MAO must immediately identify all non-credentialed participating providers and expedite their credentialing. The MAO must immediately remove all non-credentialed providers from its directory and HSD tables unless they have been given provisional status. The MAO must immediately implement quality control procedures to ensure that newly contracted providers enter the credentialing process in a timely manner to ensure Medicare enrollees are not subject to receiving services from non-credentialed providers. The MAO must submit a monthly status report to CMS including the following data: 1.The number of contracted providers who have not submitted a credentialing application. 2. Number of applications received awaiting credentialing committee decision. 3. Projected processing timeframe for receipt of outstanding applications. 4. Projected timeframe for committee review. This report is required until further notice. Submit a policy and procedure update to reflect the timeframe requirement for receipt of credentialing application subsequent to the execution of a provider contract.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 11 - Contracts	Adequate Compliance PlanThe MAO must have a formalized compliance plan that contains the requirements specified by CMS	The MAO must develop and provide to CMS: -A process for internal monitoring and auditing. -A timeframe for implementation of the process. -A workplan that will include timeframes for completion of the audits of the various departments. -A complete schedule as to which department will be monitored.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	The MAO must assure that members are notified timely no later than 30 days after reciept date of an oral or written grievance. The MAO must provide training to staff on the internal grievance process. Documentation of this training including the signatures of staff trained and a copy of the training materials must be submitted to CMS. The MAO must review and update policies and procedures relating to the grievance process.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	WHP must immediately start using OMB Approval No. 0938-0829 Form No. CMS-1003-NDP (June2001). WHP must submit a monitoring review system or process ensuring they have implemented the correct OMB form. The monitoring review system, or process must include, but not be limited to, the date of implementation, the individual who approved the implementation, and how the implementation will be monitored. WHP must submit a revised list of denial reasons for this product. Each denial reason must clearly state the reason why the claim was denied. WHP must implement a monitoring review system to ensure the correct denial reasons are displayed on all denied claims. The monitoring review system, or process must include, but not be limited to, the name of the individual who will conduct the monitoring, a schedule with the begin date and the frequency of monitoring. WHP must submit a corrected EOB to include the date field. Windsor Health Plan (WHP) must develop policies and procedures (PPs) for claim processing. The PPs must include the complete claim process from the receipt date by WHP to payment or denial. The PPs must be signed, approved by the approperiate WHP staff, and include all current Medicare regulations.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The MAO must submit a universal of pre-service denials as directed in the original June 12, 2007.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO must submit a universal of pre-service denials as directed in the original letter dated June 12, 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MAO stated that the current medical management support system was updated in June 2007. MAO must provide CMS with a universe of expedited organization determinations as requested in the June 12, 2007 audit letter. MAO must produce and provide CMS with a report indicating the number of expedited requests and the organization's determinations per month for a period of six months.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO has stated that the current medical management support system has been updated as June, 2007. Provide CMS with a universe of expedited organization determinations as requested in the June 12, 2007 audit letter. MAO must produce and provide CMS with a report that will indicate the number of expedited request per month for six months. The report must also include the timeframe for deciding the organization's determinations.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	The MAO must submit a universal of pre-service denials as directed in the orginal June 12, 2007.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Windsor Health Plan must pay claims for favorable reconsidered determinations no later than 60 calendar days after receiving the reconsideration request. WHP must establish a mechanism for ongoing monitoring of this area to ensure compliance. WHP must conduct training of appropriate staff on WHP policies and procedures for effectuating claims and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	Windsor Health Plan (WHP) must comply with the process for denying a request for an expedited reconsideration mandated by 42CFR 422.584. Additionally, WHP must comply with its own policies and procedures (WHP-GA-0022). As part of the corrective action required, WHP must develop a new notice or revise the current notice to include language from Chapter 13 80.1. WHP must submit the new material to CMS through the HPMS module for review and approval. Windsor Health Plan must conduct training of appropriate staff on required language for time frame extensions and submit documentation to the regional office that details the nature of this training including: the materials used for training, the individuals conducting the training, and the individuals being trained.	Closed
Windsor Health Group	1-615-782-7804	H5698	MA	Audit Findings	11/2/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	Windsor Health Plan (WHP) must comply with the notice content outlined in the Reconsideration Extension process mandated by 42CFR 422.590. Additionally, WHP must comply with its own policies and procedures (WHP-GA-002). As part of the corrective action required, WHP must develop a new notice or revise the current notice to include language from Chapter 13 80.1. WHP must submit the new material to CMS through the HPMS module for review and approval. Windsor Health Plan must conduct training of appropriate staff on required language for time frame extensions and submit documentation to the regional office that details the nature of this training including: the materials used for training, the individuals conducting the training, and the individuals being trained.	Closed
Wellpoint, Inc.	1-303-831-2514	H0540	MA	Ad-Hoc Compliance Event	11/1/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Wellpoint must provide CMS with a new plan of correction that will ensure that claims determinations are made correctly and timely, claims paid accurately, and interest is included when appropriate. Wellpoint must also develop a contingency plan for handling a large volume of claims as well as unexpected systems problems in order to prevent future occurrences of claims backlogs. Furthermore, Wellpoint must continue to submit bi-weekly reports to CMS that detail current number of outstanding claims broken down by age, number of clean and non-clean claims as well as the number of claims on which interest was paid. These reports should uploaded into the HPMS via the CAP Monitoring module. Wellpoint must submit a comprehensive plan of correction that will adequately address the dissatisfaction of the provider community both through provider relations and customer service. CMS understands that the dissatisfaction will subside once the claims problems are resolved. However Wellpoint must institute a diligent process for satisfying provider complaints as well as handling increasing call volumes. Lastly, Wellpoint must continue to submit bi-weekly reports to CMS that detail call volume for both members and providers, number of calls answered, percentage of calls answered, total number of abandoned calls, number of calls answered in 30 seconds, AHT, and ASA. Wellpoint must update CMS on any changes (positive or negative) to their plan of correction.	Open

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Wellpoint, Inc.	1-303-831-2514	H0540	MA	Ad-Hoc Compliance Event	11/1/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	Wellpoint must provide CMS with a new plan of correction that will ensure that claims determinations are made correctly and timely, claims paid accurately, and interest is included when appropriate. Wellpoint must also develop a contingency plan for handling a large volume of claims as well as unexpected systems problems in order to prevent future occurrences of claims backlogs. Furthermore, Wellpoint must continue to submit bi-weekly reports to CMS that detail current number of outstanding claims broken down by age, number of clean and non-clean claims as well as the number of claims on which interest was paid. These reports should uploaded into the HPMS via the CAP Monitoring module. Wellpoint must submit a comprehensive plan of correction that will adequately address the dissatisfaction of the provider community both through provider relations and customer service. CMS understands that the dissatisfaction will subside once the claims problems are resolved. However Wellpoint must institute a diligent process for satisfying provider complaints as well as handling increasing call volumes. Lastly, Wellpoint must continue to submit bi-weekly reports to CMS that detail call volume for both members and providers, number of calls answered, percentage of calls answered, total number of abandoned calls, number of calls answered in 30 seconds, AHT, and ASA. Wellpoint must update CMS on any changes (positive or negative) to their plan of correction.	Open
Wellpoint, Inc.	1-303-831-2514	H0540	MA	Ad-Hoc Compliance Event	11/1/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Wellpoint must provide CMS with a new plan of correction that will ensure that claims determinations are made correctly and timely, claims paid accurately, and interest is included when appropriate. Wellpoint must also develop a contingency plan for handling a large volume of claims as well as unexpected systems problems in order to prevent future occurrences of claims backlogs. Furthermore, Wellpoint must continue to submit bi-weekly reports to CMS that detail current number of outstanding claims broken down by age, number of clean and non-clean claims as well as the number of claims on which interest was paid. These reports should uploaded into the HPMS via the CAP Monitoring module. Wellpoint must submit a comprehensive plan of correction that will adequately address the dissatisfaction of the provider community both through provider relations and customer service. CMS understands that the dissatisfaction will subside once the claims problems are resolved. However Wellpoint must institute a diligent process for satisfying provider complaints as well as handling increasing call volumes. Lastly, Wellpoint must continue to submit bi-weekly reports to CMS that detail call volume for both members and providers, number of calls answered, percentage of calls answered, total number of abandoned calls, number of calls answered in 30 seconds, AHT, and ASA. Wellpoint must update CMS on any changes (positive or negative) to their plan of correction.	Open

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Wellpoint, Inc.	1-303-831-2514	H0540	MA	Ad-Hoc Compliance Event	11/1/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	Wellpoint must provide CMS with a new plan of correction that will ensure that claims determinations are made correctly and timely, claims paid accurately, and interest is included when appropriate. Wellpoint must also develop a contingency plan for handling a large volume of claims as well as unexpected systems problems in order to prevent future occurrences of claims backlogs. Furthermore, Wellpoint must continue to submit bi-weekly reports to CMS that detail current number of outstanding claims broken down by age, number of clean and non-clean claims as well as the number of claims on which interest was paid. These reports should uploaded into the HPMS via the CAP Monitoring module. Wellpoint must submit a comprehensive plan of correction that will adequately address the dissatisfaction of the provider community both through provider relations and customer service. CMS understands that the dissatisfaction will subside once the claims problems are resolved. However Wellpoint must institute a diligent process for satisfying provider complaints as well as handling increasing call volumes. Lastly, Wellpoint must continue to submit bi-weekly reports to CMS that detail call volume for both members and providers, number of calls answered, percentage of calls answered, total number of abandoned calls, number of calls answered in 30 seconds, AHT, and ASA. Wellpoint must update CMS on any changes (positive or negative) to their plan of correction.	Open
BlueCross BlueShield of Tennessee	1-423-535-7023	H5884	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	BCBST must submit a revision of the Notice of Denial Payment that will contain the OMB-approved language in its entirety. The Notice of Denial Payment must clearly state the service denied and the specific reason for denial.	Closed

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BlueCross BlueShield of Tennessee	1-423-535-7023	H5884	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	Blue Cross and Blue Shield of Tennessee must update and submit a copy of their policy and procedures to ensure all members are notified orally when the decision is made not to expedite their request for reconsideration. BCBSTN must conduct training of appropriate staff and submit documentation to CMS regional office that details the nature of the training, and send to the regional office a copy of training attendance log.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 11 - Contracts	Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.	University Health Care must revise all contracts to include hold harmless language that is consistent with Chapter 11, Section 100.3 of the Medicare Managed Care Manual. Documentation must be submitted to CMS that the contracts have been revised appropriately.	Closed

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University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	University Health Care must revise all contracts to include record retention requirements that are consistent with Chapter 11, Section 100.4 of the Medicare Managed Care Manual. Documentation must be submitted to CMS that the contracts have been revised appropriately.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 11 - Contracts	Adequate Compliance PlanThe MAO must have a formalized compliance plan that contains the requirements specified by CMS	University Health Care must establish a formal mechanism for ongoing internal monitoring as well as monitoring of any delegated entities to ensure continued compliance. Findings should be reviewed regularly and corrective action initiatives implemented to resolve any findings.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	University Health Care must produce a representative universe of all Part C grievances received during the audit period. The term grievances must include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes regardless of whether other words are used to describe them. This includes issues received telephonically as well as in writing.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	University Health Care must produce a representative universe of all Part C grievances received during the audit period. The term grievances must include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes regardless of whether other words are used to describe them. This includes issues received telephonically as well as in writing.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	University Health Care must produce a representative universe of all Part C grievances received during the audit period. The term grievances must include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes regardless of whether other words are used to describe them. This includes issues received telephonically as well as in writing.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	University Health Care must produce a representative universe of all Part C grievances received during the audit period. The term grievances must include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes regardless of whether other words are used to describe them. This includes issues received telephonically as well as in writing.	Closed

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University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	University Health Care must restructure the claims processing system to pend all claims that do not have a prior authorization on file rather than immediately denying the claim. While the claim is pended by Passport Advantage, it should be sent to Passport Health Plan for review and payment. If PHP pays the claim, no EOB would have needed to be issued to the member thus eliminating any member liability. However, if the claim is denied by PHP, the EOB should be issued indicating the member is indeed liable for the cost of the services. The same process should be utilized for the SNF and behavioral health services paid by Kentucky Medicaid. It is possible that PHP or KY Medicaid may not make a determination by PAD's 60th day. In these situations, PAD may deny the claim, but a denial reason code should be included stating the claim is pending a decision by Medicaid. Furthermore, University Health Care must revise it's marketing materials to clearly explain that when members seek care from non-contracted providers, it is their responsibility to obtain any necessary pre-authorizations. Second, revise all internal processes and systems to pay for out of area renal dialysis in all circumstances. Third, UHC must review all policies and procedures as well as systems programs to correct the timeframes for non-contracted providers to submit claims to follow the Medicare timely filing requirements not the Medicaid timeframes. Finally, UHC must institute a process by which vision claims that are not submitted correctly to the delegated entity are transferred in a manner that is transparent to both the beneficiary and the provider. Documentation must be submitted to confirm that all necessary steps were taken to correct these issues including the training of staff, when necessary. When training is conducted UHC should document the nature of the training including: materials used in the training, individuals conducting the training, and the individuals being trained.	Closed

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University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	University Health Care must revise it's Explanation of Benefits to comply with the requirements set forth in Chapter 13 of the Medicare Managed Care Manual which states Medicare health plans that use system-generated notifications regarding payment denials must ensure that the notification contains the OMB-approved language of the NDP in its entirety, and meets the content requirements listed in the NDP's form instructions. The standardized denial notice forms have been written in a manner that is understandable to the enrollee and must provide 1) The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, 2) Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (as mandated by 42 CFR 422.570 and 422.566(b)(3), 3) For service denials, (see Notice of Denial of Medical Coverage (NDMC), Appendix 1), a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process, 4) For payment denials, (see Notice of Denial of Payment (NDP), Appendix 1) a description of the standard reconsideration process and time frames, and the rest of the appeals process and, the beneficiary's right to submit additional evidence in writing or in person. Second, UHC must review all of its service descriptions to ensure they clearly state the service that is being denied particularly since a beneficiary commonly receives multiple services during a visit. In addition, all denial reason codes must be reviewed and revised so that they clearly indicate the reason the service is denied as well as ensure that none of the reason codes conflict with one another. All system auto-generated denial codes should be included in this review to verify that they are clear and being used appropriately. Pay particular attention to the following codes BC1, BD4, and P13 since they appeared consistently throughout the sample case files. Training should be conducted for staff on any changes made as a result of this CAP as well as the use of the manual code P73 (Medicare fee schedule paid) since this code was erroneously used for denied claims. When training is conducted UHC should document the nature of the training including materials used in the training, individuals conducting the training, and the individuals being trained. Lastly, CMS recommends that UHC revise its standard denial notice to correct the name of our agency from HCFA to CMS. The marketing material should be submitted through the marketing review process.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	University Health Care must revise its policies and procedures to ensure that it uses the standard Form No. CMS-10003-NDMC (Notice of Denial of Medical Coverage) which includes enrollee appeal rights. The plan must provide a specific and detailed explanation of why the medical services or items are being denied using clear and understandable language. University must submit the standard Form No. CMS-10003-NDMC to CMS for review and approval. Once approved by the regional office, University must include a marketing material ID and approval date on the Notice of Denial of Medical Coverage. The OMB control number must also be displayed on the notice. University Health Care must conduct training of appropriate staff on these revised policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	University Health Care must develop and implement a process to ensure that it provides a Detailed Explanation of Non-Coverage (CMS 10095-B) to members receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings. The notice must be provided no later than close of business of the day of the QIO's notification, or close of business the day before discharge, whichever is later. University Health Plan must conduct training of appropriate staff on these revised policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	University Health Care must develop and implement a process to ensure that it provides a Detailed Explanation of Non-Coverage (CMS 10095-B) to members receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings. University is required to use the standard notice. University is required to use the standard notice, CMS Form No. 10095-B, OMB No. 0938-0910 and must submit it to the regional office for review and approval. Once approved by the regional office, University must include the marketing material ID and approval as well as the OMB control number on the Detailed Explanation of Non-Coverage. University Health Plan must conduct training of appropriate staff on these revised policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	University Health Care must produce produce a representative universe of all Part C adverse claims reconsiderations received during the audit period.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	University Health Care must produce a representative universe of all Part C effectuation of third party claims reconsideration reversals received during the audit period.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member’s health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	University Health Care must produce a representative universe of all Part C favorable standard pre-service reconsiderations received during the audit period.	Closed
University Health Care, Inc.	1-502-585-7925	H1807	MA	Audit Findings	10/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member’s health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	University Health Care must produce a representative universe of all Part C adverse standard pre-service reconsiderations received during the audit period.	Closed

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Colorado Access	1-720-744-5675	H0621	MA-PD	Ad-Hoc Compliance Event	10/24/2007	Open	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	This letter is a request for a corrective action plan (CAP) from Colorado Access to address Medicare Part D contract year 2008 (CY2008) formulary development issues for Medicare Advantage Prescription Drug Plan (MA-PD) contract H0621. Throughout the CY2008 formulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that Colorado Access¿s formularies consistently contained high numbers of outliers. The source of the outliers seemed to stem from Colorado Access¿s unfamiliarity with what was expected of Part D sponsors under the 2 drugs per category/class regulatory requirements. During each stage of the formulary review process, CMS asked Colorado Access to correct all outliers: however, high numbers of outliers persisted. For example, by the third week of August 2007, late in the CY2008 formulary review process, Colorado Access¿s formularies still contained a significant number of outliers that remained to be corrected before CMS could grant final approval. The volume of formulary outliers was great enough to jeopardize Colorado Access¿s ability to have its formularies approved by CMS in time to meet Medicare and You and Part D implementation deadlines. Since an approved formulary is a component of an approvable bid, Colorado Access¿s ability to obtain a MA-PD contract for CY2008 was also at risk. Throughout this fall and into 2008, CMS expects Colorado Access will take steps to ensure that it can efficiently administer its formulary in 2008. CMS staff worked intensely with all sponsors throughout the formulary review processes during 2006 and 2007. However, during 2008, the third year of the Part D program, CMS will expect all Part D sponsors, including Colorado Access, to develop the expertise and resources necessary to complete the contract year 2009 (CY2009) formulary review process with a minimum of technical assistance from CMS. In response to this CAP request, CMS asks that Colorado Access submit the following to CMS: ¿ Updated policies and procedures regarding how Windsor will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2008 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission. ¿ A discussion of the steps Colorado Access will take to ensure it can meet the requirements for CY2009 formulary review process. This portion of the CAP should describe any arrangements Colorado Access has made ensure that it maintains adequate oversight and control over any organizations contracted with to provide formulary services on Colorado Access¿s behalf. ¿ A plan for how Windsor will ensure that the CY2008 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. This CAP will be in place through the start of the 2008 benefit year, and it will be approved once Colorado Access demonstrates it can consistently submit formularies that comply with CMS instructions. This CAP will be in place until at least May or June 2008. CMS requests that Colorado Access submit the CAP by Friday, November 16, 2007 at 5:00 p.m. EDT to: Linda Gousis Medicare Drug Benefit Group Centers for Medicare and Medicaid Services 7500 Security Blvd., Mail Stop C1-26-12	Open

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									Baltimore, MD 21244-1850 In the event your organization does not successfully satisfy this CAP, CMS will consider additional compliance actions, including the imposition of intermediate sanctions. CMS also notes that Colorado Access¿s failure to meet the Part D formulary submission and approval requirements in 2008 may result in CMS electing not to renew Colorado Access¿s Part D contracts for CY2009.	

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Valley Baptist Health System	1-512-257-6348	H4521	MA-PD	Ad-Hoc Compliance Event	10/24/2007	Open	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	This letter is a request for a corrective action plan (CAP) from Valley Baptist Insurance Company (Valley Baptist) to address Medicare Part D contract year 2008 (CY2008) formulary development issues for Medicare Advantage Prescription Drug Plan (MA-PD) contract H4521. Throughout the CY2008 formulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that Valley Baptist¿s formularies consistently contained high numbers of outliers. Examples of outliers included unacceptable quantity limits, placement of unqualified drugs in the specialty tier, not having two drugs per category/class, unauthorized negative formulary changes (e.g., formulary deletions and tier changes), and unauthorized enhancements. During each stage of the formulary review process, CMS asked Valley Baptist to correct all outliers, however, high numbers of outliers persisted. For example, by the third week of August 2007, late in the CY2008 formulary review process, Valley Baptist¿s formularies still contained a significant number of outliers that remained to be corrected before CMS could grant final approval. The volume of formulary outliers was great enough to jeopardize Valley Baptist¿s ability to have its formularies approved by CMS in time to meet Medicare and You and Part D implementation deadlines. Since an approved formulary is a component of an approvable bid, Valley Baptist¿s ability to obtain a MA-PD contract for CY2008 was also at risk. Throughout this fall and into 2008, CMS expects Valley Baptist will take steps to ensure that it can efficiently administer its formulary in 2008. CMS staff worked intensely with all sponsors throughout the formulary review processes during 2006 and 2007. However, during 2008, the third year of the Part D program, CMS will expect all Part D sponsors, including Valley Baptist, to develop the expertise and resources necessary to complete the contract year 2009 (CY2009) formulary review process with a minimum of technical assistance from CMS. In response to this CAP request, CMS asks that Valley Baptist submit the following to CMS: -Updated policies and procedures regarding how Windsor will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2008 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission. -A discussion of the steps Valley Baptist will take to ensure it can meet the requirements for CY2009 formulary review process. This portion of the CAP should describe any arrangements Valley Baptist has made ensure that it maintains adequate oversight and control over any organizations contracted with to provide formulary services on Valley Baptist¿s behalf. -A plan for how Windsor will ensure that the CY2008 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. This CAP will be in place through the start of the 2008 benefit year, and it will be approved once Valley Baptist demonstrates it can consistently submit formularies that comply with CMS instructions. This CAP will be in place until at least May or June 2008. CMS requests Valley Baptist submit the CAP by Friday, November 16, 2007 at 5:00 p.m. EDT to: Linda Gousis	Open

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									Medicare Drug Benefit Group Centers for Medicare and Medicaid Services 7500 Security Blvd., Mail Stop C1-26-12 Baltimore, MD 21244-1850 In the event your organization does not successfully satisfy this CAP, CMS will consider additional compliance actions, including the imposition of intermediate sanctions. CMS also notes that Valley Baptist¿s failure to meet the Part D formulary submission and approval requirements in 2008 may result in CMS electing not to renew Valley Baptist¿s Part D contracts for CY2009.	

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Windsor Health Group	1-615-782-7804	H1850	MA-PD	Ad-Hoc Compliance Event	10/24/2007	Open	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	This letter is a request for a corrective action plan (CAP) from Windsor Health Plans, Inc. (Windsor) to address Medicare Part D contract year 2008 (CY2008) formulary development issues for Medicare Advantage Prescription Drug Plan (MA-PD) contracts H1850 and H5698. Throughout the CY2008 formulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that Windsor¿s formularies consistently contained high numbers of outliers. Examples of outliers included having only one drug in a category and class instead of two without providing sufficient justification, inappropriate quantity limits on drugs, and inappropriate drug strengths in a specialty tier. During each stage of the formulary review process, CMS asked Windsor to correct all outliers: however, high numbers of outliers persisted. For example, by the third week of August 2007, late in the CY2008 formulary review process, Windsor¿s formularies, especially formulary ID 8544, still contained a significant number of outliers that remained to be corrected before CMS could grant final approval. The volume of formulary outliers was great enough to jeopardize Windsor¿s ability to have its formularies approved by CMS in time to meet Medicare and You and Part D implementation deadlines. Since an approved formulary is a component of an approvable bid, Windsor¿s ability to obtain MA-PD contracts for CY2008 was also at risk. Throughout this fall and into 2008, CMS expects Windsor will take steps to ensure that it can efficiently administer its formulary in 2008. CMS staff worked intensely with all sponsors throughout the formulary review processes during 2006 and 2007. However, during 2008, the third year of the Part D program, CMS will expect all Part D sponsors, including Windsor, to develop the expertise and resources necessary to complete the contract year 2009 (CY2009) formulary review process with a minimum of technical assistance from CMS. In response to this CAP request, CMS asks that Windsor submit the following to CMS: ¿ Updated policies and procedures regarding how Windsor will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2008 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission. ¿ A discussion of the steps Windsor will take to ensure it can meet the requirements for CY2009 formulary review process. This portion of the CAP should describe any arrangements Windsor has made ensure that it maintains adequate oversight and control over any organizations contracted with to provide formulary services on Windsor¿s behalf. ¿ A plan for how Windsor will ensure that the CY2008 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. This CAP will be in place through the start of the 2008 benefit year, and it will be approved once Windsor demonstrates it can consistently submit formularies that comply with CMS instructions. This CAP will be in place until at least May or June 2008. CMS requests Windsor submit the CAP by Friday, November 16, 2007 at 5:00 p.m. EDT to: Linda Gousis Medicare Drug Benefit Group Centers for Medicare and Medicaid Services 7500 Security Blvd., Mail Stop C1-26-12	Open

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									Baltimore, MD 21244-1850 In the event your organization does not successfully satisfy this CAP, CMS will consider additional compliance actions, including the imposition of intermediate sanctions. CMS also notes that Windsor¿s failure to meet the Part D formulary submission and approval requirements in 2008 may result in CMS electing not to renew Windsor¿s MA-PD or PDP contracts for CY2009.	

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Windsor Health Group	1-615-782-7804	H5698	MA-PD	Ad-Hoc Compliance Event	10/24/2007	Open	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	This letter is a request for a corrective action plan (CAP) from Windsor Health Plans, Inc. (Windsor) to address Medicare Part D contract year 2008 (CY2008) formulary development issues for Medicare Advantage Prescription Drug Plan (MA-PD) contracts H1850 and H5698. Throughout the CY2008 formulary review process, the Centers for Medicare and Medicaid Services (CMS) noticed that Windsor¿s formularies consistently contained high numbers of outliers. Examples of outliers included having only one drug in a category and class instead of two without providing sufficient justification, inappropriate quantity limits on drugs, and inappropriate drug strengths in a specialty tier. During each stage of the formulary review process, CMS asked Windsor to correct all outliers: however, high numbers of outliers persisted. For example, by the third week of August 2007, late in the CY2008 formulary review process, Windsor¿s formularies, especially formulary ID 8544, still contained a significant number of outliers that remained to be corrected before CMS could grant final approval. The volume of formulary outliers was great enough to jeopardize Windsor¿s ability to have its formularies approved by CMS in time to meet Medicare and You and Part D implementation deadlines. Since an approved formulary is a component of an approvable bid, Windsor¿s ability to obtain MA-PD contracts for CY2008 was also at risk. Throughout this fall and into 2008, CMS expects Windsor will take steps to ensure that it can efficiently administer its formulary in 2008. CMS staff worked intensely with all sponsors throughout the formulary review processes during 2006 and 2007. However, during 2008, the third year of the Part D program, CMS will expect all Part D sponsors, including Windsor, to develop the expertise and resources necessary to complete the contract year 2009 (CY2009) formulary review process with a minimum of technical assistance from CMS. In response to this CAP request, CMS asks that Windsor submit the following to CMS: ¿ Updated policies and procedures regarding how Windsor will ensure its formularies meet CMS criteria and will be updated appropriately throughout 2008 consistent with CMS instructions. These policies and procedures should include a quality control process governing each step of formulary development and submission. ¿ A discussion of the steps Windsor will take to ensure it can meet the requirements for CY2009 formulary review process. This portion of the CAP should describe any arrangements Windsor has made ensure that it maintains adequate oversight and control over any organizations contracted with to provide formulary services on Windsor¿s behalf. ¿ A plan for how Windsor will ensure that the CY2008 CMS-approved formulary will be accurately reflected in marketing materials (e.g., abridged and comprehensive formularies) and processed in claims adjudication systems. This CAP will be in place through the start of the 2008 benefit year, and it will be approved once Windsor demonstrates it can consistently submit formularies that comply with CMS instructions. This CAP will be in place until at least May or June 2008. CMS requests Windsor submit the CAP by Friday, November 16, 2007 at 5:00 p.m. EDT to: Linda Gousis Medicare Drug Benefit Group Centers for Medicare and Medicaid Services 7500 Security Blvd., Mail Stop C1-26-12	Open

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									Baltimore, MD 21244-1850 In the event your organization does not successfully satisfy this CAP, CMS will consider additional compliance actions, including the imposition of intermediate sanctions. CMS also notes that Windsor¿s failure to meet the Part D formulary submission and approval requirements in 2008 may result in CMS electing not to renew Windsor¿s MA-PD or PDP contracts for CY2009.	
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	1. SDM must provide a corrective action plan to remedy non-compliance with licensing requirements and must take immediate steps to implement that remedy. 2. SDM must provide documented corrective action to be implemented to assure that any contractors have ongoing oversight from SDM and that performance standards are documented and enforced. 3. SDM must develop documented policies for the compensation of sales and marketing staff consistent with CMS requirements.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Requirements for Post-Enrollment Materials - The Part D sponsor must distribute post-enrollment materials as required by CMS, to each enrollee in a clear, accurate, and standardized form at the time of enrollment and at least annually thereafter. This information must be provided in writing, if requested. In addition, the Part D sponsor must provide written information about its grievance and appeals procedures and the process for quality of care complaints available to the enrollee through the Quality Improvement Organization (QIO) process.	SDM must submit for review a corrective action plan and take immediate steps to implement corrective action that assures 100% compliance with the requirement that post enrollment material is accurate and received by enrollees within time parameters required by CMS.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	SDM must submit copies of contract amendments that include the LTC provisions provided in the CMS issued "Long Term Guidance."	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	SDM must develop and implement an appropriate transition process in accordance with CMS requirements. SDM must also review its existing policies and procedures and revise where necessary to comply with current regulations and CMS guidance. SDM must develop and implement a policy for periodic review of all of its policies and procedures.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	SDM must submit copies of contract amendments that include the LTC provisions provided in the CMS issued "Long Term Guidance."	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	SDM must conduct training of appropriate staff on the grievance and coverage determination processes and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	SDM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: The materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	SDM must conduct training of appropriate staff on the grievance and coverage determination processes and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA-PD	Audit Findings	10/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	SDM must conduct training of appropriate staff on the grievance and coverage determination processes and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Retroactive Enrollment Requests - The MAO requests retroactive enrollments when required, due to CMS enrollment rejection error, and adheres to CMS requirements in requesting retroactive enrollments from the Regional Office or Program Safeguard Contractor.	SDM must submit for review and immediate implementation a corrective action plan that addresses the following. 1. Compliance with instructions in Chapter 2 of the Medicare Managed Care Manual, Sections 40.4.2 and 60.4, related to cancellations, reinstatements of enrollment, and retroactive enrollment requests. 2. Review and revision of policies and procedures to outline the correct reasons for requesting a retroactive enrollment and the process to follow for retroactive enrollments. This includes following correct procedures, by reviewing RO records to ensure that SDM appropriately requests and documents requests for retroactive enrollment, and routinely used beneficiary correspondence. 3. Training of all relevant staff involved in retroactive enrollment processing. Documentation must be submitted specifying the nature of the training, materials used, who conducted and attended the training with copies of sign-in sheets.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	SDM must provide a corrective action plan to assure full compliance with CMS Marketing Guidelines requirements to submit materials for review, institute internal mechanisms to substantially improve the quality of materials submitted for review and to assure that all plan enrollees receive mandated materials consistent with parameters in CMS policies and Marketing Guidelines.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 03 - Marketing	Disclosure of Required Deemable Information to Beneficiaries - The MAO provides information on advance directives, emergency services, and policies on MA plan counseling or referral services that the MAO will not provide due to a “conscience” objection in accordance with CMS requirements.	SDM must submit a corrective action plan and immediately implement corrective actions to establish and maintain 100% compliance at all times to assure that all mandated disclosure requirements are met in all applicable materials, particularly in regard to information on advance directives, emergency services, and policies on MA plan counseling or referral services that SDM will not provide due to a 'conscience' objection.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 03 - Marketing	Disclosure of Required Non-Deemable Information to Beneficiaries - At the time of enrollment and annually thereafter, an MAO must disclose to each beneficiary electing an MA plan, in clear, accurate and consistent form the information required by CMS.	SDM must submit a corrective action plan and immediately implement corrective actions to establish and maintain 100% compliance at all times to assure that all mandated disclosure requirements are met by the timely receipt by members of EOC, SB, ANOC, member handbook and provider directory at the time of enrollment and annually thereafter.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	SDM must implement corrective actions to assure 100% compliance that copies of its approved EOC, Summary of Benefits, and information on its network of contracted providers is posted online in English and Spanish. The web site must include required marketing materials on-line. Once all marketing materials are submitted and approved in English, the Spanish version must be submitted in HPMS with a signed attestation.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	SDM must immediately revise policies referenced so that they are relevant to subject matter. In addition, SDM must submit corrective action plan to demonstrate compliance with policies in its operations. The corrective action must demonstrate that the following areas are addressed: 1. Process or mechanism in place to ensure the integrity of its marketing activities (such as information calls to recent members, marketing audits, etc.). 2. Ensures that plan rules are completely explained during the enrollment process. 3. Ensures that beneficiary election decisions are based on complete and accurate information. 4. Implement member satisfaction surveys SDM must conduct training of appropriate staff and submit documentation to the regional office that details the nature of this training including: materials used, who conducted the training, dates of training and who was trained (sign-in sheets). SDM must provide the name and title of accountable person responsible for compliance in this area.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 03 - Marketing	Appropriate Notice Given to Members Before Plan Rule Change - If the MAO intends to change its rules for an MA plan, it must give notice to all members at least 30 days before the intended effective date of the change.	SDM must revise its policy MK06 titled Notification of Rule Change as previously requested and assure compliance by means of ongoing monitoring and documented corrective action. SDM must provide the name and title of accountable individual responsible for this area.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	SDM must submit a comprehensive corrective action plan for review and approval with the objective of immediate implementation of the following: 1. Develop and implement policy on sales rep licensing and assure 100% compliance. Any activities which are outsourced to external entities must have demonstrated oversight by SDM. 2. Develop and implement policy on handling grievances related to sales and marketing activity. 3. Develop and implement policy outlining disciplinary actions for marketing infractions. 4. Specify how SDM will assure 100% operational compliance with policy MK13 titled Oversight of Marketing Activities to include provisions for reps who are employed or independent. 5. Develop and implement policy on sales reps file standardization, including what the file contents should be and how and when they are to be updated. 6. Develop policy to reflect marketing and sales staff compensation. 7. Revise policy MK10 titled Professional Conduct to actually address subject matter. SDM must provide training to all appropriate staff in these areas and submit documentation of this training to the regional office. Documentation must include: the nature and content of the training, materials used, individuals conducting the training, names of individuals trained (sign in sheets).	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	Submit a QI plan for 2007 and 2008. Submit title of person who will monitor for compliance.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 05 - Quality Assurance	Adequate Health Information System - The MAO must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its QI program.	The MAO must provide documentation of health information data reports, overview of information system and integration, committee minutes where reports are reviewed, policies and procedures for provider audits, samples of submitted provider data audits and corrective actions, analysis of member survey results, utilization reports to identify patterns of possible utilization of services, audited HEDIS reports. Submit title of person who will monitor for compliance.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	Submit UM systems reports on a quarterly basis. Submit Utilization reports for underutilization of services and over utilization of services on a quarterly basis. Submit UM Manual and UM training program materials. Submit UM systems reports on a quarterly basis.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 05 - Quality Assurance	Significant Problems Corrected - The MAO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	Submit policies and procedures for internal surveillance, complaints. Submit policy/procedure for correcting significant systemic problems. Submit title of person who will monitor for compliance.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	Submit policy/procedure for monitoring of delegated credentialing entities.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 05 - Quality Assurance	Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).	The MAO must complete a CCIP report and submit the report to the assigned MAQRO, Lumetra. MAOs are required to answer all questions asked in the CCIP report template. The report must be submitted by January 11, 2008.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 05 - Quality Assurance	Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.	SDM must submit two (2) QI project reports to the assigned MAQRO, Lumetra, by January 11, 2008. One report is to show evidence of a QI project that was initated in 2006, and one report is to show evidence of a QI project that was initated in 2007. Refer to Chapter 5 of the Medicare Managed Care Manual for details on QI project requirements and attributes. The QI report templates are to be completed as far as each project has progressed. For example, for the 2006 project, reporting is expected through the QI report template sections E, baseline data under section F, and any interventions that have been implemented thus far (section G). For the 2007 project, reporting is expected through Section E.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 06 - Provider Relations	Consultation with Physicians and Subcontracted Physician Groups - The MAO must establish a formal mechanism to consult with the physicians and subcontracted groups that have agreed to provide services regarding the organization's: medical policy, quality assurance programs, and medical management procedures.	Submit a plan for a formal mechanism to consult with physicians and subcontracted groups that have agreed to provide services regarding the organization's medical policy, quality improvement programs and medical management procedures. This must include a process for consulting with affiliated physicians and outside peer experts and communicating coverage decisions to providers. Ensure coverage policies are consistent with national Medicare Coverage determinations. SDM must submit a process for the adoption of practice guidelines and for the approval and periodical review of clinical criteria that are based on scientific advances or changes in customary practice. SDM must demonstrate clinical criteria for specific procedures are available upon request from a provider and must demonstrate that new practice guidelines are based on the needs of its population or identified variations in practice patterns. Also, SDM must ensure the dissemination of practice guidelines to physicians and select relevant guidelines to the members, and have a process for communicating practice guidelines, upon request, to all providers and enrollees including discharge criteria, continued stay and admission practice guidelines. SDM must submit to the regional office the following: Provider Manual, documentation of consultation with affiliated physicians and outside experts, coverage decision process for communicating information to physicians. SDM must submit newsletters, documentation of consultation with affiliated physicians and outside experts, clinical practice guidelines and QA minutes on a quarterly basis. SDM must submit the title of the person who will monitor this area for compliance.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Submit a plan to ensure compliance with credentialing/recredentialing regulations. Submit title of person who will monitor for compliance.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 06 - Provider Relations	Process for Consultation with Health Care Professionals Regarding CredentialingThe MAO must have a process for health care professionals' input in the credentialing process.	Submit a plan identifying the process for health care professional's input in the credentialing process with respect to criteria for credentialing and recredentialing of individual health care professionals. Submit title of person who will monitor for compliance.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Submit a plan to ensure the documented process for facility credentialing/recredentialing is followed. Submit the title of the person who will monitor for compliance.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 11 - Contracts	Adequate Compliance PlanThe MAO must have a formalized compliance plan that contains the requirements specified by CMS	SDM must provide a copy of board approved compliance Plan. This must include a work plan on the development and implementation of the requirement with timelines. Also, submit on-going documents and material to support the implementation of this requirement. Board minutes and quarterly minutes must be submitted in English to the regional office until further notice. This work plan must address areas as outlined below: approved Policies and Policies by the board, and policies and procedures (P and P) in the compliance manual, which must be signed by the appropriate persons and dated. Developed guidelines for training and education, disciplinary issues, internal monitoring and auditing and corrective action initiatives, and provide documentation of these materials and all training on who were trained and who did the training. For the 2007 Work Plan outlined in the "Medicare Programs and Compliance Department" presented to the Board on 6-20-2007, the areas for development must be added to the work plan with the timelines for completion of those areas. Provide information on when the Compliance and Quality committees listed in the Compliance Department Organization Chart will be functional and if other committees will be part of the Compliance Department, when will those committee be functional and their relationship with the Compliance Department. Each committee must be listed with the Chairperson and members. Until further notice, please send meeting minutes of the Compliance committee.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	SDM must conduct training of appropriate staff on the grievance and coverage determination processes and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its organization determinations and reconsiderations requests received by the MCO and how it correctly distinguishes between an organization determination and reconsideration. Your internal audit should evaluate whether your determinations and reconsiderations are being classified and handled appropriately within the required timeframes. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	SDM must submit an appropriate universe for this element. Once SDM produces a representative universe, the reviewer will review the element associated with the universe via a focused review and rate the elements accordingly. SDM also must establish a mechanism for its own internal ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its organization determinations and reconsiderations requests received by the MCO and how it correctly distinguishes between an organization determination and reconsideration. Your internal audit should evaluate whether your determinations and reconsiderations are being classified and handled appropriately within the required timeframes. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning with the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	SDM must submit an appropriate universe for this element. Once SDM produces a representative universe, the reviewer will review the element associated with the universe via a focused review and rate the elements accordingly. SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its organization determinations and reconsiderations requests received by the MCO and how it correctly distinguishes between an organization determination and reconsideration. Your internal audit should evaluate whether your determinations and reconsiderations are being classified and handled appropriately within the required timeframes. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	SDM must submit an appropriate universe for this element. Once SDM produces a representative universe, the reviewer will review the element associated with the universe via a focused review and rate the elements accordingly. SDM also must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its organization determinations and reconsiderations requests received by the MCO and how it correctly distinguishes between an organization determination and reconsideration. Your internal audit should evaluate whether your determinations and reconsiderations are being classified and handled appropriately within the required timeframes. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor (s), the audit methodology, and the result of the audit.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	SDM must implement Policies and Procedures or guidelines with its process for handling the processing of claims. This information must include the process with the persons and departments responsible and a reference with a list of examples of denied claims. This must include information about determining and noting whether the claim is a clean or non-clean claim. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month to determine which of its claims are correct. This audit should evaluate whether SDM is correctly determining clean and non - clean claims and if the claims are handle timely based on the determination of the claims. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified from October 2007. The summary report should include: title of the auditor (s), the audit methodology, and the results of the audit.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	SDM must develop a Policy and Procedure, which outlines its process for reasonable reimbursement for covered services. This Policy must include reimbursement relating to non-contracting provider, ambulance services, emergency and urgently needed services and other services that member may need while temporarily out of the service area. SDM must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	SDM must update its existing Policy to include information on how to handle clean and non-clean claims. This policy must have a step-by-step procedure for handling and processing received claims from non-contracted providers and the required time frames. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its claims determination. This audit should evaluate whether SDM is paying its non-contracting provider clean claims timely. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified from October 2007. The summary report should include: title of the auditor (s), the audit methodology, and the results of the audit.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	SDM must develop and implement policies and procedures and a system for paying interest for clean claims, which are paid late. SDM must submit to the Regional office information regarding the system, which it will put in place to address paying current claims, which are paid late. Also, SDM must submit documentation that the appropriate staff is trained on these policies and procedures and the documentation used in the training. Beginning with October 2007, SDM must send the regional office a listing of all clean unaffiliated provider claims (not line items) paid (not received) during the quarter. The listing should provide the claim number, date of receipt (which may be a date from an earlier quarter), paid date, and number of days it took to process. The report should provide a total of claims paid in 1-30 days, in 31-60 days, and over 60 days. (SEE SAMPLE #1 attached). This report is due to the regional office within 15 days of the close of the quarter. SDM will be required to submit this quarterly report until further notified. Sample #1 SDM - Claims Processing Results Summary Sheet for 4th Quarter Unaffiliated providers - " Clean Claims" (see format below for table) Month, Year Percentage 1 to 30 days # processed % processed 31 to 60 days # processed * % processed 61 + days # processed % processed Total Total processed 100% * Include documentation for each claim of interest computed and paid.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	SDM must develop a system to ensure non-contracted claims are adjudicated timely. This must be outlined in a Policy and Procedure or guidelines with address how unclean non - contracted claims are handled and paid. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its non-clean claims. This audit should evaluate whether SDM is adjudicating its non-clean claims timely. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified from October 2007. The summary report should include: title of the auditor (s), the audit methodology, and the results of the audit.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	SDM must develop a formalized process for administering and handling claims denial. Please revised your current Policy with guidelines outlined step by step how SDM will address timely handling of non-clean claims. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained SDM must demonstrate that it meets the requirement and must document that it appropriately administer the "Notice of Denial of Payment" (NDP) or a regional office approved modification of the NDP. SDM should conduct an internal audit each month to assess that the claim denial notice is sent and the notice clearly states the service denied and the denial reason. This audit should evaluate whether SDM is sending the notice to members. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified from October 2007. The summary report should include: title of the auditor (s), the audit methodology, and the results of the audit.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	SDM must develop guidelines which detail a step by step process on how it identifies payers that are primary to Medicare, how it will determine the amounts payable and the process for coordination of benefits. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	SDM must develop a guideline which outlines a consistent method for logging these requests so the date of receipt for the request is documented, and timeframes for handling Adverse Standard Pre-Service Organization Determination can be easily monitored. The guidelines must include information regarding an extension if required, timeframes for the extension, and when and how SDM will inform members of its decision. SDM must conduct training for the appropriate staff on these guidelines and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained See Chapter 13, Section 40 of the Medicare Managed Care Manual for guidance. SDM must submit the appropriate universe for this element for WHI. Once SDM produces a representative sample from WHI, the reviewer will review the elements associated with the universe via a focused review and rate the elements accordingly. Beginning with October 2007, SDM must send the regional office a listing with information documenting when adverse standard pre-service organization determinations are made, the date of denial and the date the extension is sent because this is justified, as well as, the date SDM makes its final decision regarding the request if an extension is requested. The denial reason must be clearly stated with the service which is being denied. This report must be submitted as a table with the timeframes and is due to the regional office within 15 days of the close of the quarter. This report must include documentation of each service request, a copy of the CMS-1003-NDMC or an RO - approved modification of the NDMC sent to the member, and any extension letter etc. SDM will be required to submit this quarterly report until further notified.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	During the review, the auditors noted that the denial letters were in English, but the denial was written in Spanish. SDM must ensure that there is an English version of this letter as well as a Spanish version (with attestation). Please ensure that these letters are reviewed and approved through the HPMS system. Also, denial reason given was not clear and was vague and confusing. SDM guideline on how it handles Adverse Standard Pre-Service Organization Determination must be developed and must include information regarding an extension if required and the timeframes associated with handling these requests. Attachments for the notices for requesting an extension and informing the members of SDM decision and the member appeal rights etc. must be part of the guidelines. SDM must also have a consistent method for logging these requests so the date of request for service is documented, and the denial reasons must be clear and precise so it is understandable what is being denied. SDM must conduct training for the appropriate staff on these guidelines and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained See Chapter 13, Section 40 of the Medicare Managed Care Manual for guidance. SDM must submit the appropriate universe for this element for WHI. CMS will then pull another sample to be reviewed. Once SDM produces a representative universe for WHI, the reviewer will review the elements associated with the universe via a focused review and rate the elements accordingly. Beginning with October 2007, SDM must send the regional office a listing with information documenting when adverse standard pre-service organization determinations are made, the date of denial and the date the extension is sent because this is justified, as well as, the date SDM makes its final decision regarding the request if an extension is requested. The denial reason must be clearly stated with the service which is being denied. This report must be submitted as a table with the timeframes and is due to the regional office within 15 days of the close of the quarter. This report must include documentation of each service request, a copy of the CMS-1003-NDMC or an RO - approved modification of the NDMC sent to the member, and any extension letter etc. SDM will be required to submit this quarterly report until further notified.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Organization Determination Requests - The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.	SDM must revise its guidelines and establish a formalized system for documenting when all Expedited Organization Determination requests are received in writing, faxed or done orally, and SDM must maintain on an ongoing basis complete records of these requests in a case file. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. Please see Chapter 13, Section 50.2 of the Medicare Managed Care Manual for guidance. SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of how its requests for Expedited Organization Determination are documented when received by fax, phone and written and whether the requests is correctly expedited. This audit should evaluate whether your determinations are being classified and handled appropriately within the required timeframes. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	SDM must provide evidence that it has a formalized system in place for receiving and documentating Expedited Organization Determination requests from members. SDM must include in its process time lines to ensure requests are handled timely. This guideline or policy and procedure must be revised to include all designated responsible parties/department and their function to process and expedite these requests timely. Please ensure that submitted policies are signed and approved by the designated persons. SDM must conduct training for the appropriate staff on these policies and procedures or guidelines and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained Please see Chapter 13, section 50 of the Medicare Managed Care guidelines	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	SDM must provide evidence of a formalized system in place for receiving and documentation of Expedited Organization Determination requests from members and the notices used in responding, and denying these requests. Please ensure that all notices to be used are approved through CMS Marketing system in HPMS. Also, the policy being used must be approved and signed off on by the appropriate persons. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained Please see Chapter 13, section 50 of the Medicare Managed Care Manual for guidance	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	SDM must put in place a process for determining and handling Organization Determination extensions. This must also be included in SDM guideline or policy and procedure for Organization Determinations, and it must be outlined who are the responsible parties/ department with information on the notices which will be used to grant an extension, as well as, inform the member of their right to file an expedited grievance. Please ensure that the notice is approved through CMS marketing process in HPMS. Also, please ensure that the policy being used is approved and signed by the appropriate persons. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. Please see Chapter 13, section 40 and 50 of the Medicare Managed Care manual for guidance.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	SDM must enhance Policy Q128 or create guidelines which address SDM process if it does not expedite an organization determination with the notices which will be used to inform members of this decision. Please ensure that submitted policies are signed and approved by the designated persons Notices must include information about SDM decision to change the expedited request to the 14 day standard timeframe, inform the member of their rights to file an expedited grievance if they disagree with SDM decision not to expedite, provide information regarding the resubmission of a request for an expedited determination with physician support, and instructions about SDM grievance process and timeframes. All notices and referenced attachments must be submitted with this guideline. SDM must conduct training for the appropriate staff on these process and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. Please refer to Chapter 13 Section 50.1 and 50.3 of the Medicare Managed Care Manual for guidance.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its organization determinations and reconsiderations requests received by the MCO and how it correctly distinguished between an organization determination and reconsideration. This audit should evaluate whether your determinations and reconsiderations are being classified and handled appropriately within the required timeframes. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	SDM must develop guidelines and/or policies and procedures regarding oversight of its delegated entities to ensure compliance with CMS requirements. Until further notice please provide documentation of SDM oversight over its delegated entities. Please submit these documents with meeting minutes from oversight committee. SDM must submit the appropriate universe for this element for WHI. CMS will then pull another sample to be reviewed. Once SDM produces a representative universe, the reviewer will review the elements associated with the universe via a focused review and rate the elements accordingly.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	SDM must develop and implement guidelines or policies and procedures that address the process and timeframe for sending the 'Detailed Explanation of Non- Coverage' to the enrollee after notification by the QIO that a fast track appeal has been filed. This document must be submitted to the Regional Office along with documentation that the appropriate staff has been trained on these policies and procedures or guidelines. Please refer to Chapter 13, Section 90.2 of the Medicare Managed Care Manual for guidance. SDM must demonstrate that it meets the requirement and must document that it appropriately administers timely the "Detailed Explanation of Non- Coverage Medicare" - 10095B to explain why SNF, HHA and CORF provider services are no longer reasonable or necessary, or are no longer covered. SDM must submit monthly reports to the regional office of all non-coverage decision issued and a copy of the notices issued, with information concerning applicable Medicare rule, instruction, or policy including citations, and how to obtain copies of these documents. SDM must monitor this function, audit compliance with this requirement, and provide monthly reporting to the regional office starting October 2007 until further notice.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	SDM developed guidelines or policies and procedures for handling and sending of the Detailed Explanation of Non-Coverage of Provider Services must include a copy of the notice. This notice must include information on why the provider services are no longer reasonable or necessary, or are no longer covered and the applicable Medicare rule, instruction, or policy with the citations and how to obtain copies of such documents, and other facts or information relevant to the non-coverage decision. Please ensure that all attachments and notices are approved through CMS marketing system in HPMS. SDM must conduct training for the appropriate staff on these policies and procedures or guidelines and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. SDM must demonstrate that it meets the requirement and must document that it appropriately administer timely the "Detailed Explanation of Non- Coverage Medicare" - 10095B to explain why SNF, HHA and CORF provider services are no longer reasonable or necessary, or are no longer covered. SDM must submit monthly reports to the regional office of all non-coverage decision issued and a copy of the notices issued, with information concerning applicable Medicare rule, instruction, or policy including citations, and how to obtain copies of these documents. SDM must monitor this function, audit compliance with this requirement, and provide monthly reporting to the regional office starting October 2007 until further notice.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Notice of Non-Coverage of Inpatient Hospital Care - The MAO must provide notice to the enrollee of its decision (or that of the delegated provider) of non-coverage of further hospital care no later than the day before hospital coverage ends when the enrollee disagrees with the discharge or noncoverage decision. Prior to issuance of this notice, the MAO secures concurrence from the physician responsible for the patient's care in the hospital. The MAO's notice of non-coverage of further inpatient hospital care must include the reason why further inpatient hospital care is no longer needed; the date and time of the enrollee's liability for continued impatient care; and the enrollee's appeal rights.	SDM must develop guidelines or policy and procedures regarding how and when the "Notice of Non- Coverage of Inpatient Hospital Care" is provided to member. This notice must include information why further inpatient hospital care is no longer needed, the date and time of the enrollee's liability for continued inpatient care, and the enrollee's appeal rights. Please ensure that this notice has been reviewed under CMS Marketing requirements in HPMS. This document must be submitted to the Regional Office along with documentation that the appropriate staff has been trained on these policies and procedures or guidelines when this notice must be provided to members. Please refer to Section 150.1 in Chapter 13 of the Medicare Managed Care Manual for guidance.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	SDM must revise its policies to reflect how it currently process reconsideration requests, and the many attachments referred to in these policies must be included. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. SDM must submit the appropriate universe for this element. Once SDM produces a representative universe, the reviewer will review the elements associated with the universe via a focused review and rate the elements accordingly.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	SDM must revise its policies to reflect how it currently process reconsideration requests, and the many attachments referred to in these policies must be included. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. SDM must submit the appropriate universe for this element. Once SDM produces a representative universe, the reviewer will review the elements associated with the universe via a focused review and rate the elements accordingly.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	SDM must revise it policies and procedures QI 29 and QI30 to reflect the process being done by SDM. The information must be clear about the designated persons or departments who will perform each function in this process. Please ensure notices referred to in these policies are attached or referral is made to where they can be found. Submitted policies must be approved and signed by the appropriate parties. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Acceptance of Standard Reconsideration Requests - The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).	SDM must revise its policy to reflect how it handles the acceptance of standard reconsideration requests. Please ensure that the correct timeframes are stated. Policies and procedures submitted must be approved and signed off on by the responsible parties. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Appropriate Person(s) Conduct the Reconsideration A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is a denial based on lack of medical necessity, the reconsidered determination must be made by a physician with the expertise in the field of medicine that is appropriate for the service at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.	For element RE02, Policy and Procedure QI30 was reviewed. SDM must revise its policy to outline how the process will occur and who are the designated people involved in the reconsideration review process. Also, see comments in RE01. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	SDM must revise it policy and outline a step by step process of whom and what department is responsible for administering this function. The submitted policy must be approved and signed off on by the appropriate persons. Also, SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its favorable standard pre-service reconsiderations. This audit should evaluate whether SDM is expediting the reconsideration requests timely. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified from October 2007. The summary report should include: title of the auditor (s), the audit methodology, and the results of the audit.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	SDM will be requested to submit a new universe to the regional Office in six months. Once SDM produce a representative universe, the reviewer will review the elements associated with the universe via a focused review and rate the elements accordingly. Also, SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained. SDM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. SDM should conduct an internal audit each month of its adverse standard pre-service reconsiderations. This audit should evaluate whether SDM is expediting the reconsideration requests timely. SDM should submit a summary report once a quarter to the regional office of its monthly findings until further notified from October 2007. The summary report should include: title of the auditor (s), the audit methodology, and the results of the audit.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	SDM must revise it policy and procedures QI 29 and QI30 to reflect the process being done by SDM. The information must be clear about the designated persons or departments who will perform each function in this process. Please ensure notices refer to in these policies copies are attached or referral is made to where they can be found. These policies must be approved and signed off on by the appropriate persons. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Reconsideration Requests - The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.	SDM must revise it policy QI29 to reflect its current process. Please ensure that this policy is approved and signed by the designated persons on the document. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	SDM must revise its policy to include a process and method that will ensure the timely handling of requests. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	SDM must revise its policy to ensure that the notice sent to the members is attached or a reference is made to where these are located and the process for sending these notices with attachments to members. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed

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SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.	SDM must revise its policies to outline the process for handling third party expedited reconsideration reversals with all persons/departments who are responsible for handling this function. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed
SDM Healthcare Management, Inc.	1-787-999-4797 Ext. 4028	H4009	MA	Audit Findings	10/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	SDM must revise its policies to include the notices used for the reconsideration extensions and the required timeframes. SDM must conduct training for the appropriate staff on these policies and procedures and provide documentation to the regional office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individuals being trained.	Closed

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Fox Rx Inc.	1-877-369-9564 Ext. 126	S5557	Part D	Ad-Hoc Compliance Event	10/18/2007	Closed	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	On September 6, 2007, the Centers for Medicare and Medicaid Services (CMS) issued an Auto-enrollment Readiness Self Audit request to Fox Rx Care (hereafter ¿Fox¿). We have reviewed your responses to that request, and have examined your recent performance under contract S5557. This letter describes decisions CMS has made regarding Fox¿s participation in auto-enrollment for contract year 2008. Operational deadlines require auto-enrollment decisions to be made by late September 2007, in order to provide beneficiaries sufficient notice of their new enrollment and plan election rights prior to the January 1, 2008 effective date of their new plan coverage. As you are aware, there is a subset of auto-enrollees CMS refers to as ¿reassignees.¿ These are LIS beneficiaries currently in a Part D plan who will be assigned to a different plan for 2008 because their current plan will have a premium above the benchmark starting January 1, 2008. Reassignments take place once a year in October and may represent a relatively large number of beneficiaries. In contrast, auto-enrollments, representing a smaller group of beneficiaries, occur on a monthly basis throughout the year as new beneficiaries become LIS-eligible. Based on our review of the findings from your Auto-enrollment Readiness Self Audit and your recent performance in the areas of customer service, licensure, financial stability, and administrative structure, we have determined that your organization is not prepared at this time to perform the tasks critical to ensure the effective transition of a large influx of LIS beneficiaries into your plan. As a result, CMS will not be reassigning any current LIS beneficiaries to your organization¿s plans during the fall of 2007. CMS has made this determination for the following reasons: - Fox has had increasing difficulties with maintaining the CMS requirements for the beneficiary call center. In recent weeks Fox has not had a toll-free customer service telephone number through which a caller can reach a live operator. CMS conducted a call center survey in September of the Fox customer toll free numbers and we were only able to reach a live operator one out of three times. The other two attempts resulted in receiving an Interactive Voice Response application to leave a message, after being on hold at least two to three minutes. A Part D sponsor must meet timely call center performance whereby 80% of all incoming calls are answered within 30 seconds: the abandonment rate does not exceed 5%: and the call center is able to meet the needs of non-English speaking beneficiaries. - CMS requires that Plan call centers provide multi-lingual services to Medicare beneficiaries. - As mentioned in our September 12, 2007 letter, Fox has been consistently late in submitting financial statements since the start of its Prescription Drug Plan operations. Because of our concerns described above, we have made the decision not to reassign beneficiaries to Fox in October 2007. However, we believe that with implementation of the changes you have described in your self-audit along with fulfillment of the existing and new corrective action plans, Fox will be ready to accept monthly auto-enrollments for 2008. Therefore, at this time we are allowing your organization to receive the monthly auto-enrollments in 2008. Should Fox fail to implement the changes described in your self-audit or the corrective action plans, CMS reserves the right to change our position on this matter.	Closed

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Fox Rx Inc.	1-877-369-9564 Ext. 126	S5557	Part D	Ad-Hoc Compliance Event	10/18/2007	Closed	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	The Centers for Medicare and Medicaid Services (CMS) is writing to express its concern that Fox Insurance Company (Fox) may not have the administrative and management arrangements necessary to operate its Medicare prescription drug plan (PDP) sponsor contract (S#5557). CMS developed this concern after Fox staff failed to return any CMS phone calls for at least two consecutive weeks during July 2007 and Fox missed several reporting requirement deadlines. The Medicare Part D regulations at 42 C.F.R. §423.504(b)(4)(ii) require PDP sponsors to maintain personnel and systems sufficient for the operation of the PDP sponsor to organize, implement, and control the furnishing of prescription drug services. CMS has reason to believe that Fox Rx is not meeting this requirement for the following reasons: - Both the CMS account manager responsible for overseeing Fox¿s contract and the CMS program analyst responsible for oversight of Fox¿s compliance with the terms of its CMS-granted waiver of the Part D risk bearing licensure requirement placed several unreturned calls to Fox staff over a two-week period during the month of July. - CMS notes that as of July 2007, almost all of the staff functions entered by Fox into the CMS Health Plan Management System (HPMS) were divided among two employees, with Jaydip Dattary holding ten positions and Anthony Arloro holding 14 positions. We question whether only two people can efficiently and effectively administer a national PDP program consistent with all of the CMS requirements. - As of July 2007, Fox did not have a general telephone number through which a caller could reach a live operator who can take messages. - Fox has been consistently late in submitting financial statements since the start of its PDP operations in January 2006. The documents that remain outstanding at this time are the independently audited financial statements (for the period ending 12/31/06) and the auditor¿s letter to Fox management providing recommendations for the elimination of identified weaknesses in Fox¿s internal controls. Both of these items were due on the 30th of April. CMS requests that Fox report back within 30 days of the date of this letter with a corrective action plan which includes the following information: 1) The overdue financial reports described above. 2) An updated response to Section 3.1.2.B. of the Medicare Prescription Drug Plan Sponsor Solicitation which requires a brief summary of the history, structure, and ownership of your organization. This submission should include an organizational chart depicting the placement of the Part D operations within your organization as well as the reporting structure within your organization. 3) A discussion of how Fox¿s current management staffing arrangements are sufficient to ensure proper administration of the Part D benefit, or Fox¿s plans for hiring additional personnel to take over responsibility for certain parts of its Part D operations. 4) A statement explaining how Fox has revised its telephone system and operational procedures to ensure prompt responses to CMS calls. CMS expects Fox to implement fully and immediately the corrective action plan it provides to CMS in response to this letter. If CMS determines that Fox¿s non-compliance with Part D requirements persists in the coming months, we may impose intermediate sanctions (e.g., suspension of marketing and enrollment activities) against Fox or pursue the termination of the Fox PDP sponsor contract.	Closed

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Coventry Health Care Inc.	1-301-581-5519	H1013	MA	Audit Findings	10/15/2007	Closed	Chapter 03 - Marketing	Materials Provided For Significant Non-English Speaking Population - For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.	The Medicare Advantage Organization (MAO) must create non-English materials in any language in which more than 10% of their service area uses a specific language other than English as its primary language. This includes marketing material used by sales agents, as well as all member material, pre-enrollment/Appeals/Grievances, etc. correspondence used to communicate plan information to the member. The Medicare Marketing Guidelines can be used as a reference to determine what materials are deemed as Marketing Materials, and therefore, should be translated into the non-English language(s).	Closed
Coventry Health Care Inc.	1-301-581-5519	H1013	MA	Audit Findings	10/15/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Vista Heatlh Plan of South Florida must revise its provider agreements to include language that will ensure that the element, CN04 - Abides by Federal Requirements provision, be included in all contracts and/or amendments accordingly. Vista Heatlh Plan of South Florida must revise its policies and procedures to ensure that element CN04 is in compliance. Vista Health Plan of South Florida must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including but not limited to: the materials used in the training, the individuals conducting the training, and the individuals being trained. Vista Heatlh Plan of South Florida must also provide a quarterly status report to CMS for the next 6 months as to the progress of this matter. Status report should include, but not limited to, the process in which the MAO intends to implement the amended language into the current provider contracts, timeline for said project, completion dates, responsible staff for each of the tasks that will be included during this process. Provider Contract Templates should be submitted for all types of MAO contracts (i.e., Direct and Downstream, etc.).	Closed
Coventry Health Care Inc.	1-301-581-5519	H1013	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must provide training for it's delegated providers regarding OC2 Denied Claims. During the interview it was discovered the OC2 sample contained both par and non par providers explaining, the reason for no Notice of Denial of Payment and Appeal Rights information/forms in the files. The MAO must submit a copy of the training provided to the delegated providers along with a copy of sign in sheet indicating who attended the training.	Closed

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Coventry Health Care Inc.	1-301-581-5519	H1013	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MAO must revise and implement policies and procedures to reflect that a member must be notified both verbally and in writing of the plan's decision regarding an expedited organizational determination, regardless of whether the decision is favorable or adverse. The MA organization must conduct appropriate staff training to ensure that notices are sent to members when an expedited decision is rendered. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct monthly self audits for one quarter. Please provide CMS with the results of these audits 30 days after completion.	Closed
Coventry Health Care Inc.	1-301-581-5519	H1013	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The MAO must develop and implement and internal policy that would enable the Health Plan to accurately provide CMS with the requested data. The MAO must conduct appropriate staff training, and provide CMS with copies of the training material and attendance roster reflecting the date and subject matter of training for the staff involved.	Closed
Coventry Health Care Inc.	1-301-581-5519	H1013	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are processed and effectuated timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self auidts and provide CMS with the results of the audit for a period not to exceed six months.	Closed
Coventry Health Care Inc.	1-301-581-5519	H1013	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Acceptance of Standard Reconsideration Requests - The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).	The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are processed and effectuated timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self auidts and provide CMS with the results of the audit for a period not to exceed six months.	Closed

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Coventry Health Care Inc.	1-301-581-5519	H1013	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	This corrective action applies to misclassified cases that were included in the sample universes for RP01. Based on the documentation presented, the reviewer has determined that the MA Organization does not have an effective process in place to properly identify and /or categorize reconsideration requests. The MA Organization is required to implement a process that will correctly identify and / or categorize reconsideration requests according to 42 CFR 422.590(a)(1). The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are appropriate classified. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA Organization must conduct quarterly self audits and provide CMS with the results of the audit for a period not to exceed six months.	Closed

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Coventry Health Care Inc.	1-301-581-5519	H1076	MA	Audit Findings	10/15/2007	Closed	Chapter 03 - Marketing	Materials Provided For Significant Non-English Speaking Population - For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.	The Medicare Advantage Organization (MAO) must create non-English materials in any language in which more than 10% of their service area uses a specific language other than English as its primary language. This includes marketing material used by sales agents, as well as all member material, pre-enrollment/Appeals/Grievances, etc. correspondence used to communicate plan information to the member. The Medicare Marketing Guidelines can be used as a reference to determine what materials are deemed as Marketing Materials, and therefore, should be translated into the non-English language(s).	Closed

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Coventry Health Care Inc.	1-301-581-5519	H1076	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must provide training for it's delegated providers regarding OC2 Denied Claims. During the interview it was discovered the OC2 sample contained both par and non par providers explaining, the reason for no Notice of Denial of Payment and Appeal Rights information/forms in the files. The MAO must submit a copy of the training provided to the delegated providers along with a copy of sign in sheet indicating who attended the training	Closed
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Coventry Health Care Inc.	1-301-581-5519	H1076	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The MAO must develop and implement and internal policy that would enable the Health Plan to accurately provide CMS with the requested data. The MAO must conduct appropriate staff training and provide CMS with copies of the training material and attendance roster reflecting the date and subject matter of training for the staff involved.	Closed

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Coventry Health Care Inc.	1-301-581-5519	H1076	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Acceptance of Standard Reconsideration Requests - The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).	The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are processed and effectuated timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self auidts and provide CMS with the results of the audit for a period not to exceed six months. [Repeat Finding]	Closed
Coventry Health Care Inc.	1-301-581-5519	H1076	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	This corrective action applies to misclassified cases that were included in the sample universes for RP01. Based on the documentation presented, the reviewer has determined that the MA Organization does not have an effective process in place to properly identify and /or categorize reconsideration requests. The MA Organization is required to implement a process that will correctly identify and / or categorize reconsideration requests according to 42 CFR 422.590(a)(1). The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are appropriate classified. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA Organization must conduct quarterly self audits and provide CMS with the results of the audit for a period not to exceed six months.	Closed

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Coventry Health Care Inc.	1-301-581-5519	H1076	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	The MA Organization must conduct appropriate staff training to ensure that requests for written and verbal expedited reconsiderations are processed timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self audits and provide CMS with the results of the audit for a period not to exceed six months.	Closed
Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 03 - Marketing	Materials Provided For Significant Non-English Speaking Population - For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.	The Medicare Advantage Organization (MAO) must create non-English materials in any language in which more than 10% of their service area uses a specific language other than English as its primary language. This includes marketing material used by sales agents, as well as all member material, pre-enrollment/Appeals/Grievances, etc. correspondence used to communicate plan information to the member. The Medicare Marketing Guidelines can be used as a reference to determine what materials are deemed as Marketing Materials, and therefore, should be translated into the non-English language(s).	Closed

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Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Vista Health Plan / Vista Health Plan of South Florida / Summit Health Plan must revise its policies and procedures to ensure that element PR03 is in compliance, specifically with the Opt Out review process. Vista Health Plan / Vista Health Plan of South Florida / Summit Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including but not limited to the materials used in the training, the individuals conducting the training, and the individuals being trained. Vista Health Plan / Vista Health Plan of South Florida / Summit Health Plan must also provide a quarterly status report to CMS for the next 6 months as to the progress of this matter. Status report should include, but not limited to, the process in which the MAO intends to implement the amended language into the policies and procedures, timeline for said project, completion dates, and responsible staff for each of the tasks that will be included during this process.	Closed
Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Summit Heatlh Plan must revise its provider agreements to include language that will ensure that the element, CN04 - Abides by Federal Requirements provision, be included in all contracts and/or amendments accordingly. Summit Heatlh Plan must revise its policies and procedures to ensure that element CN04 is in compliance. Summit Heatlh Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including but not limited to: the materials used in the training, the individuals conducting the training, and the individuals being trained. Summit Heatlh Plan must also provide a quarterly status report to CMS for the next 6 months as to the progress of this matter. Status report should include, but not limited to, the process in which the MAO intends to implement the amended language into the current provider contracts, timeline for said project, completion dates, responsible staff for each of the tasks that will be included during this process. Provider Contract Templates should be submitted for all types of MAO contracts (i.e., Direct and Downstream, etc.).	Closed
Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MAO must revise and implement policies and procedures to reflect that a member must be notified both verbally and in writing of the plan's decision regarding an expedited organizational determination, regardless of whether the decision is favorable or adverse. The MA organization must conduct appropriate staff training to ensure that notices are sent to members when an expedited decision is rendered. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct monthly self audits for one quarter. Please provide CMS with the results of these audits 30 days after completion.	Closed

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Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The MAO must develop and implement and internal policy that would enable the Health Plan to accurately provide CMS with the requested data. The MAO must conduct appropriate staff training, provide CMS with copies of the training material and attendance roster reflecting the date and subject matter of training for the staff involved.	Closed
Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are processed and effectuated timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self auidts and provide CMS with the results of the audit for a period not to exceed six months.	Closed
Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Acceptance of Standard Reconsideration Requests - The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).	The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are processed and effectuated timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self auidts and provide CMS with the results of the audit for a period not to exceed six months. [Repeat Finding]	Closed
Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	This corrective action applies to misclassified cases that were included in the sample universes for RP01. Based on the documentation presented, the reviewer has determined that the MA Organization does not have an effective process in place to properly identify and /or categorize reconsideration requests. The MA Organization is required to implement a process that will correctly identify and / or categorize reconsideration requests according to 42 CFR 422.590(a)(1). The MA Organization must conduct appropriate staff training to ensure that favorable reconsiderations are appropriate classified. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA Organization must conduct quarterly self audits and provide CMS with the results of the audit for a period not to exceed six months. [Repeat Finding]	Closed

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Coventry Health Care Inc.	1-301-581-5519	H5850	MA	Audit Findings	10/15/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	The MA Organization must conduct appropriate staff training to ensure that requests for written and verbal expedited reconsiderations are processed timely. Provide CMS with copies of the training materials in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self audits and provide CMS with the results of the audit for a period not to exceed six months.	Closed

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Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Care1st of AZ must update its policies and procedures to include the requirement that any person directly employed or contracted to market on behalf of the sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment and the sponsor did not provide documentation of the sponsors Marketing Program monitoring activities that confirm that the sponsors marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. And provide documentation that staff and contractors involved in marketing are properly trained and provide evidence of this in their CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Care1st of AZ must submit a notice consistent with CMS requirements, to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Care1st of AZ must update its policies and procedures to include, (1) procedures for providing a notice of maintenance formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. (2) a provision with a description of the procedures for providing a notice of other formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. (3) a provision including a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. (4) a provision that includes a description of the method(s) used to provide notification of formulary changes. Please refer to 42 CFR§ 423.120(b)(5)(i), 423.120(b)(5)(i), 423.578(d) and the Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans, and submit the corrected policies and procedures to CMS as part of the CAP.	Closed

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Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Care1st of AZ must update its policies and procedures to include, A provision for sending the Medicare Prescription Drug Coverage and Your Rights notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to receive such notices, a provision requiring pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception, and a provision detailing how Part D Sponsors network pharmacies meet the requirement for posting or distributing notices. Care1st must either submit documentation showing the number and percentage of network pharmacies its has audited to ensure that pharmacies are posting or distributing notices describing how members may obtain coverage determinations or request exceptions or it may develop a monitoring process and submit it along with a schedule to CMS with its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Care1st of AZ must revise its policies and procedures to include that individuals who can request a standard or expedited coverage determination are, the enrollee, the enrollees appointed representative on behalf of the enrollee, and the prescribing physician, provisions for tracking and addressing all requests for redeterminations, including a provision for quarterly reporting of all data requested in Reporting Requirements Section VII: Appeals, and documentation demonstrating it has systems to track and address in a timely manner enrollees oral and written requests for exceptions, coverage determinations, and redeterminations. Refer to 42 CFR § 423.566 (a-c) and Chapter 18 Part D Enrollment Grievances, Coverage Determinations, and Appeals, 10.4.1, 10.4.2, and 10.5 It must submit the revised policies and procedure to CMS with its CAP.	Closed

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Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Care1st of AZ must revise its policies and procedures to include a provision that the sponsor use a notice consistent with CMS-issued model notice, Notice of Case Status, which is to be sent to enrollee when the plan has sent a request to the IRE. Refer to 42 CFR § 423.568 (c)(2) and Chapter 18 Part D Enrollment Grievances, Coverage Determinations, and Appeals, 40.3.3, 40.4 and Appendix 6. It must submit the revised policies and procedure and the approved Notice of Case Status to CMS with its CAP. Care1st must describe the steps it is taking to ensure that it notifies members of standard coverage determinations within the required timeframes. Corrective action must also include a description of Care1st plans for ongoing monitoring of its performance and training of appropriate staff on the process. For the later, submit documentation that details the nature of this training, including the materials used in the training, the individuals conducting the training, the names of individuals being trained and the date training is completed, and submit to CMS as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Care1st of AZ must revise its policies and procedures to include a provision that the sponsor use a notice consistent with CMS-issued model notice, Notice of Case Status, which is to be sent to enrollee when the plan has sent a request to the IRE. Refer to 42 CFR § 423.568 (c)(2) and Chapter 18 Part D Enrollment Grievances, Coverage Determinations, and Appeals, 40.3.3, 40.4 and Appendix 6. The plan must also correct their internal coding to make sure that cases are correctly coded and resubmit corrected universe for Standard Coverage Determinations Concerning Payments (WSCD2_D) for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed

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Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Care1st of AZ must stop using the Suggested Formulary Letter and only use the Notice Denial of Medicare Prescription Drug Coverage notice, when denying Coverage Determination. The plan must also correct their internal coding to make sure that cases are correctly coded and resubmit a corrected universe for Standard Coverage Determinations Concerning Payments (Part D) (WSCD2_D) for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Care1st of AZ must update its policies and procedures to include, a provision for issuing prompt decisions on expediting determinations in accordance with CMS requirements, a statement that all oral requests must be documented in writing and that documentation of request must be maintained in case file, and a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Please refer to 42 CFR § 423.570(c)(3) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.1, 50.2 and 50.4. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Care1st of AZ must update its policies and procedures to include missing a provision for the timeliness of an expedited coverage determination denial notification following the decision to deny request for and expedited coverage determination. Please refer to 42 CFR § 423.570(d) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.3. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Care1st of AZ must update its policies and procedures to include, (1) a provision stating that oral and written notice must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations. (2) a provision that oral and written notice must inform the enrollee of the right to an expedited grievance. (3) a provision that oral and written notice must inform the enrollee or the right to resubmit a request for an expedited determination with the prescribing physicians support. (4) a provision that oral and written notice must provide instructions about the Part D sponsor¿s grievance process and timeframes. Please refer to 42 CFR § 423.570(d)(2) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.3. The plan must submit corrected Policies and Procedures as part of its CAP. Also, Care1st must submit a notice consistent with CMS-issued model notice, Notice of Right to and Expedited Grievance by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Care1st of AZ must update its policies and procedures to include, (1) A provision stating that the sponsor must make its expedited coverage determination and notify the enrollee of its decision as expeditiously as the enrollees health condition requires, but no later than 24 hours after receiving the request, or for an exceptions request, the physicians supporting statement. (2) A provision stating that if the decision is adverse and the sponsor first notifies the enrollee of the determination orally, the sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. (3) A provision stating that the sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Please refer to 42 CFR § 423.570(e), 423.572 (a-b), 423.572 (d), 423.578 (c) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.4 and 50.6. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Care1st of AZ must update its policies and procedures to include, missing a provision stating that if the decision is adverse, then the sponsor must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and must include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy CMS requirements. Please refer to 42 CFR § 423.570(c) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.5. The plan must submit corrected Policies and Procedures as part of its CAP. Also Care1st must submit a notice consistent with CMS-issued model notice, Notice of Denial of Medicare Prescription Drug Coverage by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Care1st of AZ must update its policies and procedures to include, missing provisions (1) stating that an enrollee, and enrollees appointed representative, or an enrollees prescribing physician is permitted to file a request for a tiering exception. (2) stating that if a sponsor requires a written statement from the prescribing physician, it must do so immediately. (3) stating that the physicians statement must indicate that the preferred drug for the treatment of the enrollees condition would not be effective as the requested drug and/or would have adverse effects, further the prescribing physician must demonstrate in his written statement on for the two factors. (4) that if a sponsor makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. (5) stating that the sponsor must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, in support of a tier exception request, the sponsor must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the exception. (6) that a sponsor must grant a tier exception when it determines that the preferred drug for treatment of the enrollees condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. (7) noting that the sponsor cannot restrict the number of exception requests submitted by the enrollee. Please refer to 42 CFR § 423.578(b)(1,2 and 5) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 30.2.2. The plan must submit corrected Policies and Procedures as part of its CAP. Also Care1st must submit a notice consistent with CMS-issued model notice for requesting additional information from the enrollees prescribing physician submitting it to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Care1st of AZ must update its policies and procedures to include, provisions stating that coverage is provided for approved tiering exceptions as the same cost-sharing level as preferred drugs and that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and further that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Please refer to 42 CFR § 423.578(c)(3 and 423.578(c)(4)(i-ii). The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Care1st of AZ must develop a notice that is consistent with CMS issued notice, Notice of Inquiry Regarding an Excluded Drug and submit it to CMS using HPMS to obtain approval, and submit the approve notice as part of its CAP. The plan must also correct it internal coding to make sure that cases are correctly coded and resubmit corrected universe for Standard Grievances (Part D) (Worksheet GV1_D) for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Care1st of AZ must update its policies and procedures to include a provision for tracking and maintaining, at a minimum, the date or receipt, disposition of the grievance, and the date that the enrollee was notified of the disposition, nor does the plan have documentation demonstrating its systems for capturing enrollees grievances in a centralized location. Refer to 42 CFR § 423.564 (g) to obtain this information. It must be submitted the revised policies and procedures to CMS with its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	Care1st of AZ must update its policies and procedures to include a provision for training relevant staff and contractors on grievance policies and procedures, the plan must document that it has implemented trainings on grievance policies and procedures. Examples acceptable to document this include: Attendance logs, Sign-in sheets, etc. The plan must develop and implement a training program and provide documentation of training conducted. Care1st must submit the revised/new policies and procedures to CMS with its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Care1st of AZ must develop and submit a notice consistent with CMS-issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Care1st of AZ must develop and submit a notice consistent with CMS-issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Care1st of AZ must update its policies and procedures to include missing a provision stating that all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing, a provision stating the sponsors commitment to cooperating with the QIO in resolving grievance cases, missing a provision stating that sponsor responds to quality of care grievances in writing. Please refer to 42 CFR § 423.564(e)(3)(iii) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 20.2.1. The plan must submit corrected Policies and Procedures as part of its CAP. Care1st must submit a notice consistent with CMS-issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance by submitting it to CMS using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Care1st of AZ must update its policies and procedures to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Please refer to 42 CFR § 423.586 and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.5. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Care1st of AZ must update its policies and procedures to include, provisions that names a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals, and a provision for documenting all oral request in writing, and further a provision for maintaining documentation of expedited redetermination requests in a case file. Please refer to 42 CFR § 423.570(d)(2) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 50.3. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Care1st of AZ must update its policies and procedures to include, (1) stating that the decision to accept or deny an expedited redetermination request is based on the enrollees request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollees life, health or ability to regain maximum function. (2) stating that the sponsor automatically expedites a request when the enrollees physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollees life, health, or ability to regain maximum function. (3) stating that any additional medical information the sponsor requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. Please refer to 42 CFR § 423.584(c)(2) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.8.1. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Care1st of AZ must update its policies and procedures to include, a provision stating that the sponsor must provide prompt oral notice to the enrollee, and provide equivalent written notice with 3 calendar days of the oral notice. The sponsor did not provide evidence of using a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance. Please refer to 42 CFR § 423.584(d, e) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.8.1. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed

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Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Care1st of AZ must update its policies and procedures to include, provision stating that the sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. The sponsor did not provide documentation to demonstrate use of the CMS-issued model notices, Notice of Redetermination, Request for Reconsideration, or Notice of Case Status. Please refer to 42 CFR § 423.590(a)(1-2), 423.590(c), 423.590(g)(1-4), 423.636(1), and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.1, 70.7, and 130.1. The plan must submit corrected Policies and Procedures, and the notices once they are approved by CMS as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Care1st of AZ must update its policies and procedures to include, a provision stating that the sponsor must inform the enrollee, within 24 hour, when the case is forwarded to the IRE. The sponsor did not provide documentation of use CMS-issued model notices, Notice of Redetermination, Request for Reconsideration, or Notice of Case Status. Please refer to 42 CFR § 423.636(a)(2) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.10. The plan must submit corrected Policies and Procedures as part of its CAP. Also Care1st must submit a notice consistent with CMS-issued model notices, Notice of Redetermination and Request for Reconsideration to CMS using HPMS to obtain approval, and submit the approve notice as part of its CAP.	Closed

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Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Care1st of AZ must update its policies and procedures to include, provisions (1) stating that the sponsor must inform the enrollee (and the prescribing physician involved, as appropriate) of its redetermination as expeditiously as the enrollees health condition requires, but no later than 72 hours after it received the request for an expedited redetermination. (2) indicating that notification of a favorable decision be made orally or in writing. (3) that medical information must be requested within 24 hours of the enrollees initial request. (4) that sponsor must inform enrollee within 24 hour, when the case is forwarded to the IRE. Please refer to 42 CFR § 423.584 (e), 423.590(d-e), 423.638(a) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.8.1. The plan must submit corrected Policies and Procedures as part of its CAP. Also, Care1st must submit a notice consistent with CMS-issued model notices, Notice of Redetermination and Request for Reconsideration to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Care1st of AZ must update its policies and procedures to include a provision for authorizing or providing the benefits in dispute within 72 hour required timeframe. Please refer to 42 CFR § 423.638(a) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 130.2.2. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Care1st of AZ must update its policies and procedures to include a provision stating that if the issue is a denial based on lack of medical necessity, then the sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Please refer to 42 CFR § 423.590(f)) and Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.6. The plan must submit corrected Policies and Procedures as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Care1st of AZ must update its policies and procedures to include, provisions stating that case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file, and that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. The plan must develop a process to make sure it sends the required notices to members. Please refer to Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 70.20, 70.30 and Appendix 6. The plan must submit corrected Policies and Procedures, and process to monitor notices being sent to members as part of its CAP.	Closed

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Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Care1st of AZ must submit a notice consistent with CMS-issued model notices, Notice of Effectuation to Part D Independent Review Entity to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP. Please refer to Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 130.3.1 and Appendix 9.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Care1st of AZ must submit a notice consistent with CMS-issued model notices, Notice of Effectuation to Part D Independent Review Entity to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP. Please refer to Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 130.3.1 and Appendix 9.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA-PD	Audit Findings	10/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Care1st of AZ must update its policies and procedures to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollees health requires but no later than 24 hours after the date it receives notice reversing the decision. Please refer to Prescription Drug Benefit Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 130.3.1 and Appendix 9. The plan must submit corrected Policies and Procedures as part of its CAP. Also, Care1st must submit a notice consistent with CMS-issued model notices, Notice of Effectuation to Part D Independent Review Entity to CMS by using HPMS to obtain approval, and by submitting the approved notice as part of its CAP.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Care 1st AZ must describe the actions it is taking to ensure that it provides written notice to Medicare members 30 days prior to PCP or other provider terminations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits to ensure compliance with CMS requirements.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Care 1st AZ must describe the actions it is taking to ensure that it and its delegated entities credential/recredential contracted providers in accordance with CMS requirements, on a timely basis. Corrective action must include policy and procedure revisions for the health plan as well as its delegated entities. It must include internal health plan audits as well as delegation oversight audits of credentialing files to ensue compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Care1st of AZ must describe the actions it is taking to ensure that it is meeting the member notification requirements for grievances in accordance with CMS policy and regulations. As part of the required corrective action, Care1st must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Care1st of AZ must describe the actions it is taking to ensure that it is meeting the member notification requirements for grievances in accordance with CMS policy and regulations. As part of the required corrective action, Care1st must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	Care1st of AZ must describe the actions it is taking to ensure that it is meeting the member notification requirements for grievances in accordance with CMS policy and regulations. As part of the required corrective action, Care1st must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Care1st of AZ must send CMS compliant notices (the standardized Notice of Denial of Payment) to members when it denies claims from non-contracted providers. The description of denied services and the denial reasons used with the notice must be clear and understandable. As part of the required corrective action, Care1st must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	Care1st of AZ must revise its policies and procedures to include the requirements noted in the deficiency above. Care1st submitted revised policies and procedures dated June 2007 which includes these provisions and no additional corrective action is required.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Care1st of AZ must revise its policies and procedures to ensure that claims are processed timely. Care1st must establish and maintain effective oversight to ensure that claims are processed according to CMS requirements for timeliness.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Care1st of AZ must describe the actions it is taking to ensure that interest paid on clean claims from non-contracted providers is in accordance with CMS policy and regulations. As part of the required corrective action, Care1st must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	Care1st of AZ must revise its policies and procedures to ensure that claims are processed timely. Care1st must establish and maintain effective oversight to ensure that claims are processed according to CMS requirements for timeliness.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Care1st of AZ must send CMS compliant notices (the standardized Notice of Denial of Payment) to members when it denies claims from non-contracted providers. The description of denied services and the denial reasons used with the notice must be clear and understandable. As part of the required corrective action, Care1st must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	Care1st of AZ must revise its policies and procedures to include the requirements noted in the deficiency above. Care1st submitted revised policies and procedures dated June 2007 which includes these provisions and no additional corrective action is required.	Closed

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Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Care 1st AZ must describe the actions it is taking to ensure that it is meeting the timeliness and member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	Care1st of AZ must develop a standard notice to members that explains that you will process the request using the standard timeframe, informs the member of the right to file a grievance if they disagree with the decision not to expedite, informs the member of the right to resubmit a request for an expedited reconsideration with any physicians support, and provide instructions about your grievance process and its timeframes.	Closed
Care1st Health Plan	1-602-778-1850 Ext. 8318	H5430	MA	Audit Findings	10/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	Care1st of AZ must develop a standard notice to members informing them that you are taking an extension on their reconsideration request and that they have the right to file an expedited grievance about this decision. Please submit via HPMS for review and approval as well as with the corrective action plan.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	Mid Rogue must develop an ongoing quality improvement (QI) program and quality work plan that is formally evaluated at least annually. Mid Rogue must (1) develop a quality assurance program description, (2) develop a quality work plan that includes an annual review process, (3) incorporate information from customer service, appeals and grievances, medical management, credentialing, provider relations, claims, sales, and marketing in its quality assurance program,(4) ensure that quality activities are reflected in quality minutes,(5) ensure that quality and broad minutes are signed and dated,(6) report quality information and quality indicators to its board,(7) ensure that information reported to the board is reflected in quality and board minutes,(8) revise organizational charts to reflect the appropriate structure, oversight, and reporting responsibilities of the quality committee,(9)develop a process that will encourage providers to participate in CMS and HHS quality improvement initiatives,(10)include dual eligible Special Needs Medicare enrollees (SNP) as a specific focus for QI planning and QI projects, (11) ensure that any variations between Mid Rogue Health Plan's Medicare Advantage enrollees and its Special Needs enrollees are clearly reflected in all policies, procedures, and training, 12) train appropriate staff on QI policies and procedures,(13) implement the policies and procedures,(14) provide the Seattle Regional Office (RO) with documentation on the training as follows:the materials used, the names and titles of the person(s)providing the training,and the name and position of each individual that received the training, and(15) for each of the prior fourteen tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	Mid Rogue must(1)develop an appropriate Medicare Advantage UM Program that meets CMS requirements. At a minimum the UM program must include written policies and procedures that reflect Medicare coverage guidelines, National Coverage Determinations and local medical review polices, 2)develop UM reports that help identify patterns of over and under utilization of services,(3)develop a formalized process to conduct clinical peers review decisions to deny authorization on grounds of medical appropriateness in a consistent manner,(4)formally adopt practice guidelines that are appropriate for Medicare enrollees. Where there are variations between coverage determinations for Special Needs Medicare Advantage enrollees(SNP), Mid Rogue must clearly state and explain variations in all UM policies and procedures,(5)ensure UM criteria is reviewed and approved by a committee of professionals that include practicing and participating providers,(6)communicate UM practice guidelines and UM criteria to providers through newsletter articles, provider educational trainings, and provider manuals,(7)established an inter-rater reliability process to esnure thatUM reviews are consistent and in accordance with established criteria,(8)ensure UM policies and procedures for its Medicare Advantage enrollees include explicit time frames for completing and communicating UM decisions to enrollees and providers,(9)develop case management activities,(10)ensure UM activities do not provide incentives to deny,limit, or discontinue Medicare service(11)train appropriate staff on UM policies and procedures,(12)provide the Seattle Regional Office(RO)with documentation of the training, the name and position of each staff member that received UM training, staff that conducted training, and details regarding the nature of the training, including the materials used in the training,and(13)for each of the prior twelve tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 05 - Quality Assurance	Significant Problems Corrected - The MAO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	Mid Rogue must(1)develop a formal mechanism(s)to ensure that it promptly corrects significant systematic problems that come to its attention through internal surveillance, complaints, or other mechanisms,(2)develop and implement policies and procedures to identify and assess the severity of identified problem(s) and that allows the MAO to take timely and specific action to correct identified problem(s),(3)develop a process to incorporate and implement information or changes from member satisfaction surveys, 4)develop a formalized Medicare quality of care review process, (5)train appropriate staff on internal surveillance and complaints policies and procedures,(6)provide the Seattle Regional Office (RO) with documentation of the training, the name and position of each staff member that received UM training, staff that conducted training, and details regarding the nature of the training, including the materials used in the training, 10) for each of the prior 9 tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 05 - Quality Assurance	Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).	Submit to the evaluation entity, MAQRO, evidence that there are systematic processes and procedures in place to appropriately identify members with the CCIP's targeted conditions. The procedure must specify the frequency of data mining and should include how a member is to be notified of his, or her, eligibility. Submit to MAQRO, a written protocol for monitoring enrollee's participation in the program: specify the elements or attributes that are monitored for the CCIP participants, the staff roles involved in the CCIP monitoring and the frequency that the monitoring occurs. Submit to MAQRO, a timeline for implementation of a disease management data base system that the CCIP staff can use to effectively track CCIP participant progress.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 05 - Quality Assurance	Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.	Review the requirements and documentation standards related to Quality Improvement (QI) project methodology and quality indicators in the QI Instructional Guide and Chapter 5 of the Medicare Managed Care Manual. For the 2007 QI project, construct valid QI indicators and performance targets, and ensure that the data sources are appropriate. Resubmit a revised 2007 QI project report to the evaluation entity, MAQRO.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Mid Rogue Health Plan must establish and maintain effective oversight of its delegated entities to ensure that they follow a documented process for initial credentialing and recredentiling. Mid Rogue Health Plan must (1) ensure its delegated entities include quality of care information collected through the MAO¿s Quality Improvement (QI) Program, (2) develop policies and procedures requiring delegated entities to follow a documented process for credentialing and recredentialing. If the delegated entity does not include quality indicators in its credentialing and recredentialing processes, develop policies and procedures as to how the MAO will incorporate QI indicators into the delegated credentialing and recredentialing files, (3) implement the policies and procedures, (4) train appropriate staff on the policies and procedures, (5) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (6) conduct internal audits of all credentialing and recredentialing files, (7) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of the entities, (8) provide a summary report to the (RO) every three months until all of the contracts are amended. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (9) develop a delegated agreement which specifies CMS requirements and includes the following provisions: activities being delegated, reporting responsibilities of the delegated entity, revocation of delegated activities and/or remedies for inadequate performance, and (10) for each of the prior nine tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action. (Cross reference QI01 and QI07)	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Mid Rogue Health Plan must follow a documented process for facilities regarding initial credentialing and recredentialing. Mid Rogue Health Plan must (1) develop policies and procedures for selection and evaluation of facilities. The policies and procedures must specify that the MAO will determine at specified intervals that the facility is licensed to operate in the State, in compliance with all applicable State and Federal requirements including the requirement to be Medicare certified, and reviewed and approved by an accrediting body or meets the standards established by the organization itself, (2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of all credentialing files, (6) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of the facilities, (7) provide a summary report to the RO every three months until all of the facilities are credentialed. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, and (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Mid Rogue Health Plan must establish and maintain effective oversight of its delegated entities to ensure that their contracts with downstream entities contain the provision to maintain records for a minimum of 10 years. Mid Rogue Health Plan must (1) ensure its delegated entities amend all of their contracts to include the provision, (2) develop policies and procedures describing the types of oversight it will implement for ongoing monitoring of its delegated entities, (3) implement the policies and procedures, (4) train appropriate staff on the policies and procedures, (5) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (6) conduct internal audits of all contracts, (7) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of the entities, (8) provide a summary report to the RO every three months until all of the contracts are amended. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, and (9) for each of the prior eight tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Mid Rouge Health Plan must notify the member of its decision as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. Mid Rouge Health Plan must (1) revise policies and procedures to ensure that it notifies the member of its decision no later than 30 days after the receipt date of the oral or written grievance. The MAO must submit the revised policies to CMS for review, (2) implement the polices and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits if its Grievance Decision Notification Timeliness process. The audits should evaluate if grievance decisions are being provided to members timely, and if appropriate 14 day extension is taken and members are notified appropriately (6) provide the RO with a mock-up report that demonstrates ongoing monitoring , (7) provide a summary report to the (RO) every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, and (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Mid Rouge Health Plan must inform the member of the organization's disposition of the grievance. For Quality of Care issues, it must include the right to file a written complaint with the QIO. Mid Rouge Health Plan must (1) revise policies and procedures including provisions that the MAO notifies a member of the organization's disposition of the grievance. For Quality of Care issues, it must include the right to file a written complaint with the QIO. Mid Rogue must submit the revised policies to CMS for review, (2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of all Grievance case files (WS GV1), (6) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (7) provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	Mid Rouge Health Plan must respond to written grievances in writing. Mid Rouge Health Plan must (1) revise policies and procedures to ensure that it responds to written grievances in writing, (2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of its Grievance Decision Notification procedures, (6) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (7) provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Mid Rogue Health Plan must achieve and maintain effective oversight of correct claim determinations, which include developing the claim for additional information. Mid Rogue Health Plan must (1) develop and implement policies and procedures requiring staff to develop claims for the necessary information needed in order to make a correct claim determination, (2) train appropriate staff on the policies and procedures, (3) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4) conduct internal audits of denied claim determinations on a monthly basis. The audits must evaluate whether denied claims were developed when additional information was required to make a claim determination, what professional level of staff reviewed the documentation and made a claim determination, whether the development was documented and if Medicare guidelines and MAO policies and procedures were evaluated in the coverage decision, (5) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of its processes and progress, (6) provide a summary report to the (RO) every month until further notified, and (7) for each of the prior six tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Mid Rogue Health Plan must achieve and maintain effective oversight of claim payment timeliness in order meet the CMS requirement to pay ninety five percent of clean claims from non-contracting providers within 30 calendar days of receipt. Mid Rogue Health Plan must (1) develop and implement policies and procedures requiring staff to pay claims timely. The policies and procedures must include processes for the entire claim flow from mail room to claim entry and must include provisions to identify and resolve paper claim backlogs in a timely manner, (2) train appropriate staff on the policies and procedures, (3) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4) conduct internal audits of all clean, non-contracted provider paid claims on a monthly basis. The audits must evaluate whether clean, non-contracted provider claims were paid within 30 days of receipt (5) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of its processes and progress. The report should include the total paid claims, the totals claims paid in 1-30 days, and the total paid in over 30 days. (6) provide a summary report to the (RO) every month until further notified, and (7) for each of the prior six tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Mid Rogue Health Plan must achieve and maintain effective oversight of correct interest payments in order meet the CMS requirement to pay correct interest on clean non-contracted provider claims paid in over 30 days. Mid Rogue Health Plan must (1) develop a work plan that describes its provisions to resolve interest underpayments in its claim system, (2) conduct internal audits of all non-contracted provider interest payments on a monthly basis. The audits must evaluate whether clean, non-contracted provider claims, paid in over 30 days, were paid interest in accordance with regulations (3) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of its processes and progress. The report should include the total number of non-contracted provider claims paid with interest, the date of receipt, paid date, provider claim payment amount without interest, and the interest payment, (4) provide a summary report to the (RO) every month until further notified, and (5) for each of the prior four tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Mid Rogue Health Plan must send the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)) to its members when it denies claims, and achieve and maintain effective oversight of claim denial notices. Mid Rogue Health Plan must (1) develop and implement policies and procedures requiring the issuance of the written NDP, (2) train appropriate staff on the policies and procedures, (3) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4) conduct internal audits of all denied claims on a monthly basis. The audits must evaluate whether each denied claim has resulted in the issuance of an NDP or an RO approved modification of the NDP, and if the denial clearly states the service denied and the denial reason (5) provide the RO with a mock-up report that demonstrates how it will report on its monitoring of its processes and progress. The report should include the total number of denied claims, the number of NDP¿s issued, and the number of clear denial reasons, (6) provide a summary report to the (RO) every month until further notified, and (7) for each of the prior six tasks of this correction action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Mid Rouge Health Plan must notify the member in writing of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified), if it makes an adverse standard pre-service organization determination. Mid Rouge Health Plan must (1) revise polices and procedures (including "desk guides/procedures") that address any portion of the Standard Pre-Service Organization Determination process and describe the timelines and issuance of its decision,(2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of Standard Pre-Service Organization Determination process and timelines, (6) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (7) provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Organization Determination Requests - The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.	Mid Rouge Health Plan must establish an efficient and convenient means for individuals to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file. Mid Rouge Health Plan must (1) revise its polices and procedures (including "desk guides/procedures") to ensure that members can submit expedited requests both orally and in writing, all oral requests are documented in writing, and all case related documentation is maintained in a case file, (2) implement the policies and procedures, (3) train appropriate staff on the policies and procedures, (4) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (5) conduct internal audits of the receipt and documentation of expedited organization determination requests process, (6) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (7) provide a summary report to the RO every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, (8) for each of the prior seven tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA	Audit Findings	10/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Reconsideration Requests - The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.	Mid Rogue Health Plan must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file. Mid Rogue Health Plan must (1) revise polices and procedures (including "desk guides/procedures") to ensure that members can submit expedited requests both orally and in writing, all oral requests are documented in writing, and maintained in an appropriate case file, (2) implement the policies and procedures, (4) train appropriate staff on the policies and procedures, (3) provide the CMS regional office (RO) with documentation on the training as follows: the materials used, the names and titles of the person(s) providing the training, and the name and position of each individual that received the training, (4) conduct internal audits of the Expedited Reconsideration Request process, (5) provide the RO with a mock-up report that demonstrates how it will report on its ongoing monitoring, (6) provide a summary report to the (RO) every three months until further notice. The summary report should include the title of the auditor(s), the audit methodology, and the results of the audit, and (7) for each of the prior six tasks of this corrective action request, clearly state in its corrective action plan when it expects to complete the corrective action.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The M+CO establishes and maintains a marketing system for confirming that enrolled members understand that they are enrolled in the M+C plan, and understand the rules applicable under the plan.	Upon discovery of the problem, SHMD made several changes to its outbound verification process. SHMD identified all beneficiaries who had not received outbound calls and who were still enrolled in the plan, and proceeded to make outbound education calls to those members. Changes have been implemented to the outbound call selection process which has effectively remedied the administrative error that resulted in the failure to call new members initially. Additionally, the plan has put into place several reporting criteria to ensure that in the future, all enrollments will be forwarded to the contracted service for outbound verification activities. The plan has submitted documentation to support that its systems have been sufficiently enhanced to ensure that all newly enrolled members will be selected for outbound verification activities. To demonstrate the effectiveness of the changes implemented to the outbound education and verification process SHMD will be required to make the following reports to CMS weekly December through April and monthly during the lock in period May through November: 1)Report reflecting the numbers of new enrollments received, the number of successful first call attempts, the number of education letters sent when the initial attempt to call is unsuccessful, results of call attempts two and three, number of incoming calls in response to the education letter that result in the verification script being completed. 2)Report reflecting the results of calls made to beneficiaries. This report should demonstrate at a minimum the number of calls made and the potential outcomes, ie: unable to reach, refused, request disenrollment, request cancellation, failed to understand any of the concepts addressed through the script, etc. 3)Report reflecting the performance of FMOs and individual brokers based upon the education calls conducted. Overall performance as well as trend information should be presented in these reports. 4)Report reflecting the actions taken by SHMD in response to data analysis of outbound education activities.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	SHMD must continue to enhance its oversight program for agents In May 2007, CMS issued additional guidance to PFFS plans requiring sufficient training to ensure that agents comprehend the plan, that plans provide oversight of their employed and contracted agents by investigating complaints and analyzing sales data for trends including rapid disenrollment rates. SHMD has implemented the recommendations and marketing materials now contain the required disclaimer making clear to the reader the type of plan being advertised and promoted. New training and recertification programs have been enhanced in content and in the way it is administered to agents. The testing process has been revised to limit agents to 2 attempts followed by a third proctored exam. If the agent does not pass, they will be prohibited from selling the plan for the remainder of the selling year. Remedial training will make use of similar enhancements. CMS also acknowledges that SHMD has revised its process allowing for quicker termination of agents that continue to evidence complaints about their sales presentations. SHMD must document continued oversight by providing to CMS the meeting minutes of the Distribution Oversight Committee (DOC), along with any reports or recommendations and analysis by the Watch List Committee, responsible for investigating sales incidents. CMS acknowledges that many policies have been revised to create a complete framework for required documentation of sales agent performance. An additional review of 20 recently recertified sales agents indicate that sufficient corrective action has been taken to establish a proper documentation process for agent files. CMS will require the following reports as a means of demonstrating the effectiveness of the actions already taken by SHMD: 1) Develop a report that documents new training and required re-certification training to all employed and contracted agents who may present the PFFS plan to Medicare beneficiaries. The frequency of this report should be weekly until all agents are trained. Training provided to new agents throughout the year should be communicated monthly. 2) Develop a report that documents training to existing sales agents, employed and contracted, resulting from an incident investigation or other corrective action. 3) Revise the current report that documents investigation of sales complaints. The report should provide a summary description of the allegation, a description of the action(s) taken by SHMD and the number of complaints received for that agent within the last year. Currently, the report does not provide details beyond the category of the complaint, nor does the report detail the specific actions taken by the plan. 4) Develop a revised Rapid Disenrollment Report that arrays the rapid disenrollment rates for all contracted FMOs and sub delegated entities on a monthly basis using a running year. The reports currently received do not break out the timeframe for performance and wraps up the entire year. This report will be retrospective in nature and may change over time given beneficiary requests for retroactive disenrollments. Currently SHMD does not factor into its rapid disenrollment rates retroactive disenrollments processed beyond the 90 day defined period for rapid disenrollments. CMS requests that the plan develop and implement a system for the tracking of retroactive changes to a member¿s enrollment that results in a rapid disenrollment, and then factor those into overall performance statistics for agents. Disenrollments of this nature may provide greater insight into the actual rapid disenrollment rates of the agents and FMOs responsible for presenting this product. When rapid disenrollment rates at the FMO reflect higher than the desired rates per plan guidelines, additional detail should be provided for the specific agents with higher than acceptable rates of rapid disenrollments.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 04 - Benefits and Beneficiary Protections (Access and Availability)	Access to services under an M+C private fee-for-service plan (sufficient access) - The Non-Network PFFS plan establishes a provider "deeming" process to provide access to its enrolled beneficiaries and demonstrates access by paying amounts that are at least the Medicare payment rate.	In May 2007, SHMD submitted a corrective action plan in response to the numerous provider complaints received by CMS relative to this finding. In that CAP, SHMD began the process of developing a system to link NCD and LMRP to their claims processing system. Until that process is complete this information is being managed through an external system. SHMD must provide an update to the implementation of a more comprehensive mechanism to maintain information relative to NCD and LMRP and to integrate that information directly into the claims processing system. Please provide a specific timeline for the full implementation. To ensure provider participation, the SHMD payment dispute resolution process must become more user friendly and meet the needs of the provider community. Specific requests for corrective action relative to the provider dispute resolution process will be addressed in element PR206. Additionally, SHMD must make its customer service provider inquiry lines more useful to the provider community and staff it appropriately with trained individuals capable of answering questions about payments and resolving issues at the earliest possible level. SHMD has taken the preliminary step to create a dedicated Provider Education Specialist unit. These representatives have received specific training on the PFFS product and will be able to respond to the issues raised by providers. As further demonstration of the efforts taken to address the customer service needs of the provider community, SHMD has submitted the training materials and the revised policies and procedures that customer service representatives will use to escalate issues to subject matter experts as appropriate. Provide an overview of how SHMD will monitor the responsiveness of PES staff as they respond to provider inquiries. Provide any revised policies and procedures that address customer service interaction with providers about payment or coverage disputes.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The M+CO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	SHMD must submit the applicable policies and procedures put into place to address the need to identify opt out physicians and take appropriate action to prevent payment to those providers. These policies should also reference that when the opt out list is analyzed, any provider who had received payment during the last quarter will be contacted to refund any monies paid for Medicare covered services. Submit all of the policies and procedures put into place to implement this new process	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 06 - Provider Relations	Provider Payment Appeal System - M+C Private fee for service plans must establish and maintain a payment appeal system under which providers may have their payment claims reviewed in the event that a provider believes he was paid less than he would have been paid under Original Medicare. Providers must demonstrate that they have not received proper payment and the plan must then pay the difference between what the provider originally received and what he would have received under Original Medicare.	SHMD must take the following actions to ensure that its provider dispute resolution process is more effective in resolving issues related to claims payment and coverage. 1)Implement more effective management oversight of the provider dispute process. Management must be able to ensure through ongoing internal audits and review of management reports that provider disputes are being processed within the stated timeframes and that all levels of appeal are being addressed. Develop a report to share with CMS that demonstrates the numbers and types of reconsiderations and appeals brought to the plan and the corresponding decisions made. Timeliness of the processes should be demonstrated in these ongoing reports. This report should be provided monthly to CMS. 2)SHMD must revise its written policies and procedures for provider dispute resolution to incorporate a more interactive process that allows providers to communicate with SHMD and to present evidence as necessary to further support the pending dispute. The process must incorporate a review of any additional information presented in the reconsideration or appeal, speak with the provider if requested to do so, and ensure that the additional information provided is used to make the next level of decision on the dispute. Submit revised policies and procedures demonstrating that such a process exists. 3)Correspondence to providers must be clear. The dispute determination, notice of reconsideration or appeal, must specifically reference the reason that the payment will not be changed or that the service will continue to be denied. If additional documentation had been presented, that must be addressed in the decision. Additionally, correspondence to the provider involving appeal determinations should always remind the provider that if they disagree with the revised decision rendered by SHMD and if the provider has evidence of a different determination rendered by Original Medicare, that such documentation should be submitted to SHMD for consideration in the next level of appeal. 4)The PFFS contract with Medicare requires that there be a reasonable process in place to resolve provider payment disputes. Case samples reflected that many reconsideration reviews resulted in a new and different denial reason for the service in question. In those cases where the rationale for denial has changed, the appeal process must be extended to allow the provider the opportunity to rebut the new determination. Additionally, when the denial reason changes, the notice issued to the provider should not explain that this is the last of the appeal processes available to the provider. Please revise policies and procedures to accurately reflect this requirement.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Organization Determinations and Reconsiderations Not Categorized as Grievances - The M+CO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	SHMD must evaluate more thoroughly the intake process for complaints and analyze whether the data is truly reflective of the number and range of complaints received. It is critical that complaint data be used to identify where members and providers are encountering difficulty navigating through the plan¿s complex structure to resolve outstanding problems. Submit the analysis of the complaint intake process, its ability to capture verbal grievances and whether the customer service representatives are accurately representing the issues that come to their attention.	Open

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Grievance Adjudication - The M+CO must adjudicate internal grievances in a manner fully consistent with the M+CO's written grievance procedure, as stated in the EOC.	SHMD must ensure that customer service representatives take appropriate action in response to member complaints. Conduct a review of existing policies and procedures to ensure that they contain sufficient guidance to staff on how to document requests for assistance from other components or to request that another component investigate a particular issue. SHMD must also have the management capacity to review staff interactions with members to ensure that the information conveyed to members is complete and appropriate for the situation. If not already in place, SHMD should implement internal audits of plan interactions with members for the purposes of performance review and to assess training needs. SHMD must describe the processes in place to ensure that representatives are adhering to the plan guidelines and provide report formats that demonstrate appropriate management oversight. Additionally, the formal grievance process must become more responsive to the needs of members who have been unable to locate a provider willing to accept the plan¿s terms and conditions. SHMD has a process to solicit provider information from new enrollees at the point of application and then make contact with those providers who have not already acknowledged that they are willing to participate with the plan. In addition to assisting the beneficiary locate a provider who has agreed to accept the plan¿s terms, when complaints of this nature are received, the providers identified in that form should be re-contacted to advise the provider of the circumstances involving the member. Develop adequate policies and procedures to address member complaints where providers are unwilling to accept the plan¿s terms and conditions and to assist those members in locating alternative providers who have agreed.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	SHMD must take the following actions to improve its claim processing systems and to provide accurate claims decisions to providers and members. 1)SHMD must analyze the use of the denial reasons inserted into PRAs. As evidenced in the claims reviewed, many reasons do not adequately explain to the provider what actions must be taken to either re-submit the claim for payment or dispute the determination rendered. SHMD must make revisions to any denial reason that does not clearly communicate necessary information to the providers. Submit to CMS for review the revised list of denial reasons and the situations in which those reasons would be applied to denied claims. 2)SHMD must ensure that denial communication to providers makes clear what types of denied services are intended to result in member liability. The current PRA references member liability in a field that does not appear on the document. Many denial reasons do not address the issue of member liability. SHMD must provide to CMS an overview of how they plan to communicate member liability within the PRA so that the provider knows what can be billed to the Medicare beneficiary. 3)SHMD must also have a process in place to identify the systemic issues that may be represented by complaints in the claims or customer service systems that result in overturn decisions. Providers report making multiple complaints that do not generate any change in approach by the plan. SHMD must take action to begin to analyze the information coming from providers through its customer service and claims departments to more quickly identify repetitive patterns of overturn and make changes to the coverage guidelines as indicated. Submit the process to be implemented to achieve this goal and any reports that will be generated as a result of the analysis.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Claim Denials (Notice Content) - If an M+CO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	SHMD must analyze the denial reasons used to populate member EOBs and revise those that are not clear and which do not adequately reflect member liability. Revised denial reasons and the guidelines for their use must be submitted as evidence of the corrective actions taken. Additionally, SHMD must analyze how it communicates claim denial information to members so that the EOB adequately expresses what has been denied, what might be billed to the beneficiary and whether there is liability for the denied services. Submit revised policies and procedures that will govern this process as well as revised denial explanations that will be used to communicate this information to members.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5435	MA	Audit Findings	10/9/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Payment rates under PFFS plan - M+CO must demonstrate to CMS that it has payment rates that are not less than the rates that apply under original Medicare for the provider in question.	See CAR for AA201 and PR206.	Closed
Quality Health Plans, Inc.	1-727-945-8400 Ext. 102	H5402	MA	Audit Findings	10/5/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	Quality Health Plan must conduct training of appropriate staff on this requirement and submit documentation to the regional office that details the nature of this training including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Quality Health Plans, Inc.	1-727-945-8400 Ext. 102	H5402	MA	Audit Findings	10/5/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.	Quality Health Plan must conduct training of appropriate staff on their Policy and Procedure MS 24, Enrollment Acceptance/Rejection. Quality Health Plan must submit documentation to the regional office that details thenature of the training to include, the materials used, the individuals conducting the training, and the individuals trained. Quality Health Plan must submit a monthly detailed report to the regional office of rejected enrollment transactions. The report must include the beneficiary's name, HICN, date of enrollment, date rejected, date rejection letter sent, and a copy of the rejection letter. The first report is due to the regional office by November 15, 2007 and should be sent by the 15th of each month until further notice.	Closed
Quality Health Plans, Inc.	1-727-945-8400 Ext. 102	H5402	MA	Audit Findings	10/5/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	Quality Health Plan must follow their own Policy and Procedure MS 24 Enrollment Acceptance/Rejection. Quality Health Plan must provide training on this procedure to appropriate staff and submit documentation to the regional office that details the nature of the training, materials used, individuals conducting the training, and individuals being trained.	Closed
Quality Health Plans, Inc.	1-727-945-8400 Ext. 102	H5402	MA	Audit Findings	10/5/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	1.) Quality Health Plans must submit a copy of revised procedures to ensure all unaffiliated provider paid claims are processed and paid within the 30 day CMS requirement. Quality Health Plans must conduct training of appropriate staff on the revised Policy and Procedures and submit documentation to CMS regional office that details the nature of this training and provide a copy of the training attendance log. 2.) Beginning November 2007, Quality Health Plans must send a monthly detailed clean claims report to the regional office. The report must show the date the claim was received, date paid, and pended for the month. The report is due to the regional office by the 15th of the month. Quality Health Plans will be required to submit these reports until further notice.	Closed

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Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	(A) KPCA must revise its policies and procedures to include the requirement that those conducting marketing must provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. (B) KPCA needs to explain what actions it will take to ensure that field sales executives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	KPCA must revise its policies and procedures to include the missing provision "...or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug." If this language is sited in another section, cross referencing to the section with appropriate language would be helpful. The KPCA representative also shared with us the unique KPCA process by which a pharmacist handles the situation when a beneficiary comes to the pharmacy to find there drug is no longer on formulary. CMS suggests that KPCA you include the processes in this section of the policy and procedures.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	KPCA must revise its policies and procedures to include the provision stating that the Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in the plan's service area that requests the contract.	Closed

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Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	KPCA must revise its plan policies and procedures to include (1) A provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices. Or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. (2) A provision requiring pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception. (3) A provision detailing how Part D sponsor's network pharmacies meet the requirement for posting or distributing notices. (4) Documentation showing the number and percentage of network pharmacies it has audited to ensure that pharmacies are positing or distributing notices describing how members may obtain coverage determinations or request exceptions or it may develop a monitoring process and submit it along with a schedule to CMS with its CAP. KPCA should add the description of this process in their Policy and procedures.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	KPCA must revise its policies and procedures to include the missing provisions 1) telephone number or fax number for receiving oral requests, 2) a provision for making expedited decisions outside of normal business hours.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	KPCA must revise its policies and procedures to include the following requirements: (1) States the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities and special language requirements, if any. (2) Provides information regarding the right to appoint a representative to file and appeal on the enrollee's behalf. (3) Provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	KPCA must revise its policies and procedures to include the requirement regarding the process at the pharmacy when a beneficiary shows up at the pharmacy with a non formulary prescription.	Closed

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Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	(A) KPCA must advise CMS how it plans to communicate to members whether their complaints are subject to grievance or coverage determination procedures. (B) KPCA must add the required language to their Notice of Denial of Medicare Prescription Drug Coverage for excluded drugs found in the model located at Appendix 12 - (Model) Notice of Inquiry, in Chapter 18 of the Prescription Drug Benefit Manual.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	KPCA must revise its policy and procedure to include a provision for training relevant staff on grievance polices and procedures.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	KPCA needs to explain what actions it will take to ensure that KPCA is meeting the timeliness standards for grievances in accordance with CMS policy and regulations. The corrective action must include a detailed description of KPCA's internal monitoring activities to ensure compliance for this element.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	KPCA must revise its policies and procedures to include the provision that states that the plan must document all oral redetermination requests in writing when received.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	KPCA must revise its policies and procedures to include the missing provision stating that the plan must request any additional medical information within 24 hours of receiving initial requests for expedited redeterminations from the member and/or the prescribing physician.	Closed

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Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	KPCA must revise its policies and procedures to include the missing provision stating that the plan must inform enrollees within 24 hours when it forwards cases to the IRE.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	KPCA must revise its policies and procedures to include the missing provision stating that the plan must inform enrollees within 24 hours when it forwards cases to the IRE.	Closed

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Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	KPCA must revise its policies and procedures to include the missing provision stating that the plan must request any supporting or necessary medical information from members and/or prescribing physicians within 24 hours of receiving the request.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA-PD	Audit Findings	10/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	KPCA needs to explain what actions it will take to ensure that redetermination case files are forwarded to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. The corrective action must include a detailed description of KPCA's internal monitoring activities to ensure compliance with this element.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	KPCA must describe the actions KPCA will take to ensure that correct claim determinations are made, including development of the claim for additional information when necessary. KPCA also needs to describe the actions KPCA will take to monitor this function for ongoing compliance, which would include a time line with goals for training, implementation and compliance with the requirements described under this element.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	KPCA must analyze the interest payment process to determine the cause of the interest calculation error. Submit to CMS KPCA analysis including the reason for the calculation error and corrective action to ensure interest is paid accurately. Also, KPCA must provide an estimated date to implement the process corrections.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions KPCA will take to ensure it is meeting the timeliness standards for standard pre-service organization determinations in accordance with CMS policy and regulations. The process must include internal health plan audits to ensure compliance with CMS requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	Describe the actions KPCA will take to ensure the timely and appropriate issuance of the DENC to Medicare beneficiaries for appealed services in the SNF, HHA, or CORF. The process must include internal health plan audits to ensure compliance with CMS requirements.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	KPCA must describe the actions it will take to ensure that it pays and notifies members of its overturn decision within the CMS's required 60 days timeframe from the date it receives a request for reconsideration.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H0524	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	KPCA needs to explain what actions the plan will take to ensure that standard pre-service reconsideration cases for which KPCA is unable to make a fully favorable decision it will forward to the independent review entity within the CMS's required timeframe of 30 days (or an additional 14 calendar days if an extension is justified). The corrective action must include a detailed description of KPCA's internal monitoring activities to ensure compliance for this element.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6050	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	KPCA must describe the actions KPCA will take to ensure that correct claim determinations are made, including development of the claim for additional information when necessary. KPCA also needs to describe the actions KPCA will take to monitor this function for ongoing compliance, which would include a time line with goals for training, implementation and compliance with the requirements described under this element.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6050	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	KPCA must analyze the interest payment process to determine the cause of the interest calculation error. Submit to CMS KPCA analysis including the reason for the calculation error and corrective action to ensure interest is paid accurately. Also, KPCA must provide an estimated date to implement the process corrections.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6050	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions KPCA will take to ensure it is meeting the timeliness standards for standard pre-service organization determinations in accordance with CMS policy and regulations. The process must include internal health plan audits to ensure compliance with CMS requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6050	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	Describe the actions KPCA will take to ensure the timely and appropriate issuance of the DENC to Medicare beneficiaries for appealed services in the SNF, HHA, or CORF. The process must include internal health plan audits to ensure compliance with CMS requirements.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6050	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	KPCA must describe the actions it will take to ensure that it pays and notifies members of its overturn decision within the CMS's required 60 days timeframe from the date it receives a request for reconsideration.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6050	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	KPCA needs to explain what actions the plan will take to ensure that standard pre-service reconsideration cases for which KPCA is unable to make a fully favorable decision it will forward to the independent review entity within the CMS's required timeframe of 30 days (or an additional 14 calendar days if an extension is justified). The corrective action must include a detailed description of KPCA's internal monitoring activities to ensure compliance for this element.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6052	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	KPCA must describe the actions KPCA will take to ensure that correct claim determinations are made, including development of the claim for additional information when necessary. KPCA also needs to describe the actions KPCA will take to monitor this function for ongoing compliance, which would include a time line with goals for training, implementation and compliance with the requirements described under this element.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6052	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	KPCA must analyze the interest payment process to determine the cause of the interest calculation error. Submit to CMS KPCA analysis including the reason for the calculation error and corrective action to ensure interest is paid accurately. Also, KPCA must provide an estimated date to implement the process corrections.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6052	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions KPCA will take to ensure it is meeting the timeliness standards for standard pre-service organization determinations in accordance with CMS policy and regulations. The process must include internal health plan audits to ensure compliance with CMS requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6052	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	Describe the actions KPCA will take to ensure the timely and appropriate issuance of the DENC to Medicare beneficiaries for appealed services in the SNF, HHA, or CORF. The process must include internal health plan audits to ensure compliance with CMS requirements.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6052	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	KPCA must describe the actions it will take to ensure that it pays and notifies members of its overturn decision within the CMS's required 60 days timeframe from the date it receives a request for reconsideration.	Closed
Kaiser Foundation Health Plan, Inc.	1-626-405-5479	H6052	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	KPCA needs to explain what actions the plan will take to ensure that standard pre-service reconsideration cases for which KPCA is unable to make a fully favorable decision it will forward to the independent review entity within the CMS's required timeframe of 30 days (or an additional 14 calendar days if an extension is justified). The corrective action must include a detailed description of KPCA's internal monitoring activities to ensure compliance for this element.	Closed
Spectrum Health System	1-616-464-8424	H2320	MA	Audit Findings	10/4/2007	Closed	Chapter 06 - Provider Relations	Discrimination Against Health Care Professionals ProhibitedAn MAO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.	Priority Health should update its policies and procedures, as well as its Provider Manual, to incorporate the regulatory requirements at 42 CFR Part 422.205. Specifically, Priority should include the provision that an MA organization cannot discriminate in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her licensure or certification under State law, solely on the basis of the license or certification.	Closed
Spectrum Health System	1-616-464-8424	H2320	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Priority Health Plan needs to ensure that it uses the (CMS-10003-Notice of Denial of Payment (NDP)), or an RO approved modification of the (NDP). The notice to the member must clearly state the service denied and the denial reason.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Spectrum Health System	1-616-464-8424	H2320	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	FINDINGS: RP02, NOT MET. Per RP02 Auditing Element requirement: Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action. CORRECTIVE ACTION REQUIRED (CAR) I.Policies and Procedures A.Develop policies and procedures In the event that Priority Health DOES NOT HAVE A CURRENT POLICY AND PROCEDURE pertaining to Auditing Element RP02, Priority Health must develop and implement a policy and procedure, or policies and procedures to make certain that (Adverse Standard Pre-Service Reconsiderations (Timeliness) standards are met. Copies of this information must be submitted to the Regional Office. Priority Health, when and if necessary, conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. B.Revise policies and procedures In the event that Priority Health HAS AN EXISTING POLICY AND PROCEDURE it must be reviewed, and as necessary, revised, in order to meet the required standards for Auditing Element RP02. As necessary, Priority Health must also conduct training of appropriate staff on any new and / or revised policies and procedures. Copies of this information must be submitted to the Regional Office. Priority Health must submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Spectrum Health System	1-616-464-8424	H2320	MA	Audit Findings	10/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	FINDINGS: RP03, NOT MET Per RP03 Auditing Element requirement: Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. CORRECTIVE ACTION REQUIRED (CAR) I. Policies and Procedures A. Develop policies and procedures In the event that Priority Health DOES NOT HAVE A CURRENT POLICY AND PROCEDURE pertaining to Auditing Element RP03, Priority Health must develop and implement a policy and procedure, or policies and procedures to make certain that (Effectuation of Third Party Standard Pre-Service Reconsideration Reversals) standards are met. Copies of this information must be submitted to the Regional Office. Priority Health, when and if necessary, conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. B. Revise policies and procedures In the event that Priority Health HAS AN EXISTING POLICY AND PROCEDURE it must be reviewed, and as necessary, revised, in order to meet the required standards for Auditing Element RP03. As necessary, Priority Health must also conduct training of appropriate staff on any new and / or revised policies and procedures. Copies of this information must be submitted to the Regional Office. Priority Health must submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO submitted a Corrective Action Plan. There is a new process to ensure that the sales force is trained and the files will indicate date tested and rapid disenrollment rates.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; · Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO submitted a Corrective Action Plan. There is a new process to ensure that the sales force is trained and the files will indicate date tested and rapid disenrollment rates.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	No CAP required.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must advise CMS upon implementation of the new systems conversion for the EOB to include the correct notice.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO provided CMS with a corrective action while onsite. The MAO has taken the necessary steps to enusre that the notice is in accordance with CMS' requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	This is a repeat finding. The MAO must submit a OP5 universe to CMS by the 5th of each month. In addition, the MAO will provide provider education regarding CMS' notice requirements, monitor providers for timely delivery of the notice, and if the MAO does not receive a copy of the notice, it will automatically extend the services for a minimum of 48 hours and advise the provider by telephone or in writing (fax) not to proceed with the termination of services (i.e. discharge) until the letter is delivered.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	This is a repeat finding. The MAO must submit a OP5 universe to CMS by the 5th of each month. In addition, the MAO will provide provider education regarding CMS' notice requirements, monitor providers for timely delivery of the notice, and if the MAO does not receive a copy of the notice, it will automatically extend the services for a minimum of 48 hours and advise the provider by telephone or in writing (fax) not to proceed with the termination of services (i.e. discharge) until the letter is delivered.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	The MAO submitted a Corrective Action Plan while onsite. The MAO has implemented a revised policy to ensure that the reconsiderations are processed timely.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	The MAO submitted a Corrective Action Plan while onsite. The MAO has implemented a revised policy to ensure that the reconsiderations are processed timely.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO submitted a Corrective Action Plan. There is a new process to ensure that the sales force is trained and the files will indicate date tested and rapid disenrollment rates.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO submitted a Corrective Action Plan. There is a new process to ensure that the sales force is trained and the files will indicate date tested and rapid disenrollment rates.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	No CAP required.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must advise CMS upon implementation of the new systems conversion for the EOB to include the correct notice.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO provided CMS with a corrective action while onsite. The MAO has taken the necessary steps to enusre that the notice is in accordance with CMS' requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	This is a repeat finding. The MAO must submit a OP5 universe to CMS by the 5th of each month. In addition, the MAO will provide provider education regarding CMS' notice requirements, monitor providers for timely delivery of the notice, and if the MAO does not receive a copy of the notice, it will automatically extend the services for a minimum of 48 hours and advise the provider by telephone or in writing (fax) not to proceed with the termination of services (i.e. discharge) until the letter is delivered.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	This is a repeat finding. The MAO must submit a OP5 universe to CMS by the 5th of each month. In addition, the MAO will provide provider education regarding CMS' notice requirements, monitor providers for timely delivery of the notice, and if the MAO does not receive a copy of the notice, it will automatically extend the services for a minimum of 48 hours and advise the provider by telephone or in writing (fax) not to proceed with the termination of services (i.e. discharge) until the letter is delivered.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	The MAO submitted a Corrective Action Plan while onsite. The MAO has implemented a revised policy to ensure that the reconsiderations are processed timely.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	The MAO submitted a Corrective Action Plan while onsite. The MAO has implemented a revised policy to ensure that the reconsiderations are processed timely.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO submitted a Corrective Action Plan. There is a new process to ensure that the sales force is trained and the files will indicate date tested and rapid disenrollment rates.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO submitted a Corrective Action Plan. There is a new process to ensure that the sales force is trained and the files will indicate date tested and rapid disenrollment rates.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	No CAP required.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must advise CMS upon implementation of the new systems conversion for the EOB to include the correct notice.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO provided CMS with a corrective action while onsite. The MAO has taken the necessary steps to enusre that the notice is in accordance with CMS' requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	This is a repeat finding. The MAO must submit a OP5 universe to CMS by the 5th of each month. In addition, the MAO will provide provider education regarding CMS' notice requirements, monitor providers for timely delivery of the notice, and if the MAO does not receive a copy of the notice, it will automatically extend the services for a minimum of 48 hours and advise the provider by telephone or in writing (fax) not to proceed with the termination of services (i.e. discharge) until the letter is delivered.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	This is a repeat finding. The MAO must submit a OP5 universe to CMS by the 5th of each month. In addition, the MAO will provide provider education regarding CMS' notice requirements, monitor providers for timely delivery of the notice, and if the MAO does not receive a copy of the notice, it will automatically extend the services for a minimum of 48 hours and advise the provider by telephone or in writing (fax) not to proceed with the termination of services (i.e. discharge) until the letter is delivered.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	The MAO submitted a Corrective Action Plan while onsite. The MAO has implemented a revised policy to ensure that the reconsiderations are processed timely.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	The MAO submitted a Corrective Action Plan while onsite. The MAO has implemented a revised policy to ensure that the reconsiderations are processed timely.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO submitted a Corrective Action Plan. There is a new process to ensure that the sales force is trained and the files will indicate date tested and rapid disenrollment rates.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO submitted a Corrective Action Plan. There is a new process to ensure that the sales force is trained and the files will indicate date tested and rapid disenrollment rates.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	No CAP required.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must advise CMS upon implementation of the new systems conversion for the EOB to include the correct notice.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO provided CMS with a corrective action while onsite. The MAO has taken the necessary steps to enusre that the notice is in accordance with CMS' requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	This is a repeat finding. The MAO must submit a OP5 universe to CMS by the 5th of each month. In addition, the MAO will provide provider education regarding CMS' notice requirements, monitor providers for timely delivery of the notice, and if the MAO does not receive a copy of the notice, it will automatically extend the services for a minimum of 48 hours and advise the provider by telephone or in writing (fax) not to proceed with the termination of services (i.e. discharge) until the letter is delivered.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	This is a repeat finding. The MAO must submit a OP5 universe to CMS by the 5th of each month. In addition, the MAO will provide provider education regarding CMS' notice requirements, monitor providers for timely delivery of the notice, and if the MAO does not receive a copy of the notice, it will automatically extend the services for a minimum of 48 hours and advise the provider by telephone or in writing (fax) not to proceed with the termination of services (i.e. discharge) until the letter is delivered.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	The MAO submitted a Corrective Action Plan while onsite. The MAO has implemented a revised policy to ensure that the reconsiderations are processed timely.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	The MAO submitted a Corrective Action Plan while onsite. The MAO has implemented a revised policy to ensure that the reconsiderations are processed timely.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	1.The MAO must identify and amend all first tier and downstream contracts that do not comply with the required contract provisions. 2.The MAO must provide a summary report of contracts identified as not containing the required contract provision and indicate when a contract amendment was sent. 3.The MAO must provide the regional office with a sample of the amendment used.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	1. The MAO must develop and implement policies and procedures for grievance processing. 2. The MAO must train appropriate staff on the definition of a grievance, the differences between appeals and grievances and how to handle cases that are improperly identified as grievances. 3. The MAO must submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 4. The MAO must conduct an internal audit each month of grievance processing. This audit must evaluate whether requests for grievances are accurately tracked, monitored and resolved in accordance with policy and procedure, and meets CMS requirements. The audit must determine whether the grievances are accurately and thoroughly documented. 5. The MAO must submit a summary report monthly to the regional office of its findings. The summary report must include: name and title of auditor(s), the audit methodology, and its results. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	1. The MAO must develop and implement grievance policies and procedures. 2. The MAO must train appropriate staff on the definition of a grievance, the differences between appeals and grievances, the handling of cases that are improperly identified as grievances as well as appropriate resolution of a grievance and documentation of resolution. 3. The MAO must submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 4. The MAO must conduct an internal audit each month of grievance processing. This audit must evaluate whether requests for grievances are accurately tracked, monitored and resolved in accordance with policy and procedure, and meets CMS requirements. The audit must determine whether the grievances are accurately and thoroughly documented. 5. The MAO must submit a summary report monthly to the regional office of its findings. The summary report must include: name and title of auditor(s), the audit methodology, and its results. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	1. The MAO must develop and implement grievance policies and procedures. 2. The MAO must train appropriate staff on the definition of a grievance, the differences between appeals and grievances, the handling of cases that are improperly identified as grievances as well as appropriate resolution of a grievance and documentation of resolution. 3. The MAO must submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 4. The MAO must conduct an internal audit each month of grievance processing. This audit must evaluate whether requests for grievances are accurately tracked, monitored and resolved in accordance with policy and procedure, and meets CMS requirements. The audit must determine whether the grievances are accurately and thoroughly documented. 5. The MAO must submit a summary report monthly to the regional office of its findings. The summary report must include: name and title of auditor(s), the audit methodology, and its results. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	1. The MAO must develop and implement grievance policies and procedures. 2. The MAO must train appropriate staff on the definition of a grievance, the differences between appeals and grievances, the handling of cases that are improperly identified as grievances as well as appropriate resolution of a grievance and documentation of resolution. 3. The MAO must submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 4. The MAO must conduct an internal audit each month of grievance processing. This audit must evaluate whether requests for grievances are accurately tracked, monitored and resolved in accordance with policy and procedure, and meets CMS requirements. The audit must determine whether the grievances are accurately and thoroughly documented. 5. The MAO must submit a summary report monthly to the regional office of its findings. The summary report must include: name and title of auditor(s), the audit methodology, and its results. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	1. The MAO will be required to submit a new universe and sample case files for Denied Claims per the Regional Office Plan Manager's instructions. 2. The MAO must revise/develop its policies and procedures to instruct the claims processing staff to develop for missing or incorrect claim information when the beneficiary is liable. 3. The MAO must conduct training of the appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 4. The MAO must conduct an internal audit each month of a denied claim sample. This audit must evaluate whether the claims processor is developing for missing information, prior to issuing a denial. The MAO must submit a summary report monthly to the regional office of its findings until further notified. The summary report must include: name and title of the auditor(s), the audit methodology, the results of the audit, and any recommendations or resolutions implemented to correct deficiencies identified. 5. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	1. The MAO will be required to submit a new universe and sample case files for Denied Claims per the RO Plan Manager's instructions. 2. The MAO must revise/develop its policies and procedures to instruct the claims processing on how to identify a clean claim. 3. The MAO must conduct training of the appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 4. The MAO must conduct an internal audit each month of a denied claim sample. 5. The MAO must submit a summary report monthly to the regional office of its findings until further notified. The summary report must include: name and title of the auditor(s), the audit methodology, the results of the audit, and any recommendations or resolutions implemented to correct deficiencies identified. 6. The MAO must establish a mechanism for ongoing monitoring, tracking and reporting of clean claims.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO will be required to submit a new universe and sample case files for Denied Claims per the RO Plan Manager's instructions.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Organization Determination Requests - The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.	1. The MAO will be required to submit a universe and sample case files, per the RO Plan Manager's instructions. 2. The MAO must develop a process to identify requests for expedited organization determinations and distinguish such requests from standard organization requests. 3. The MAO must implement its policy and procedure for processing expedited requests and train appropriate staff in the handling and documentation of expedited organization determinations. 4. The MAO must conduct monthly internal audits to monitor compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	1. The MAO will be required to submit a universe and sample case files, per the RO Plan Manager's instructions. 2. The MAO must develop a process to identify requests for expedited organization determinations and distinguish such requests from standard organization requests. 3. The MAO must implement its policy and procedure for processing expedited requests and train appropriate staff in the handling and documentation of expedited organization determinations. 4. The MAO must conduct monthly internal audits to monitor compliance with CMS requirements.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	1. The MAO will be required to submit a universe and sample case files, per the RO Plan Manager's instructions. 2. The MAO must develop a process to identify requests for expedited organization determinations and distinguish such requests from standard organization requests. 3. The MAO must implement its policy and procedure for processing expedited requests and train appropriate staff in the handling and documentation of expedited organization determinations. 4. The MAO must conduct monthly internal audits to monitor compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	1. The MAO will be required to submit a universe and sample case files, per the RO Plan Manager's instructions. 2. The MAO must develop a process to identify requests for expedited organization determinations and distinguish such requests from standard organization requests. 3. The MAO must implement its policy and procedure for processing expedited requests and train appropriate staff in the handling and documentation of expedited organization determinations. 4. The MAO must conduct monthly internal audits to monitor compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	1. The MAO will be required to submit a universe and sample case files, per the RO Plan Manager's instructions. 2. The MAO must develop a process to identify requests for expedited organization determinations and distinguish such requests from standard organization requests. 3. The MAO must implement its policy and procedure for processing expedited requests and train appropriate staff in the handling and documentation of expedited organization determinations. 4. The MAO must conduct monthly internal audits to monitor compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	1. The MAO will be required to submit a universe and sample case files, per the regional office Plan Manager's instructions. 2. The MAO must develop a process to identify requests for expedited organization determinations and distinguish such requests from standard organization requests. 3. The MAO must implement its policy and procedure for processing expedited requests and train appropriate staff in the handling and documentation of expedited organization determinations. 4. The MAO must conduct monthly internal audits to monitor compliance with CMS requirements.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	1. The MAO must provide the regional office with a policy and procedure of the process developed to ensure that members are notified timely of organization decisions (including authorizations for service). 2. The MAO must provide a policy and procedure for tracking, monitoring and documenting notifications. 3. The MAO must develop a standard notice and train appropriate staff on the notification requirements. 4. The MAO must conduct an internal audit each month to ensure that the MAO complies with CMS requirements regarding member notifications. This audit must evaluate whether notifications are accurately tracked, monitored and resolved in accordance with policy and procedure, and meets CMS requirements. 5. The MAO must submit a summary report monthly to the regional office of its findings. The summary report must include: name and title of auditor(s), the audit methodology, and its results. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	1. The MAO must develop a policy and procedure outlining the process for tracking receipt date for organization determinations and document each step of the appeal process. The MAO is required to send the enrollee written notification by close of business on the date the QIO notification was received. 2. Policies and Procedures must be developed or revised to map the workflow of the QIO review of termination of services in a clear, detailed manner, outlining each step, task, responsibility as well as timeline to include other departments as appropriate (e.g. Claims, Utilization Management, Customer Service, Provider Relations and the Medical Director). 3. The MAO must conduct an internal audit each month of appeals processing. This audit must evaluate whether requests for organization determinations and appeals are accurately tracked, monitored and resolved in accordance with policy and procedure, and meets CMS requirements. The audit must determine whether the organization determinations are accurately and thoroughly documented. 4. The MAO must submit a summary report monthly to the regional office of its findings. The summary report must include: name and title of auditor(s), the audit methodology, and its results. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	1. Policies and procedures must be developed or revised to map the workflow in a clear, detailed manner, outlining each step, task, responsibility as well as timeline to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director) if those departments are involved in the reconsideration process. 2. The MAO must develop internal controls to ensure that favorable claim reconsiderations are adjudicated timely. 3. The MAO must develop a formal process for ongoing monitoring of this area to ensure compliance with Medicare requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	1. The MAO will be required to submit a universe and sample case files for Unfavorable Claim Reconsiderations per the RO Plan Manager's instructions. 2. The MAO must develop policies and procedures that clearly map the workflow of the appeals staff, including but not limited to the identification of each specific step, task, responsibility and day to day oversight of the reconsideration requirements. 3. The MAO must develop processes to ensure that beneficiary claims reconsiderations are correctly categorized separate from any provider dispute appeal process.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	1. The MAO will be required to submit a new universe and sample case files for Unfavorable Claim Reconsiderations per the RO Plan Manager's instructions. 2. The MAO must develop policies and procedures that clearly map the workflow of the appeals staff, including but not limited to the identification of each specific step, task, responsibility and day to day oversight of the reconsideration requirements. 3. The MAO must develop processes to ensure that beneficiary claims reconsiderations are correctly categorized separate from any provider dispute appeal process.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	1. The MAO will be required to submit a new universe and sample case files for Favorable Standard Pre Service Reconsiderations, per the RO Plan Manager's instructions. 2. Policies and procedures must be developed or revised to map the workflow in a clear, detailed manner, outlining each step, task, responsibility as well as timeline to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director) if those departments are involved in the process. 3. The MAO must develop internal controls to ensure that favorable pre-service reconsiderations are processed timely.	Closed
Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	1. The MAO will be required to submit a new universe and sample case files for Unfavorable Standard Pre Service Reconsiderations. 2. Policies and procedures must be developed or revised to map the workflow in a clear, detailed manner, outlining each step, task, responsibility as well as timeline to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director) if those departments are involved in the process. 3. The MAO must develop internal controls to ensure that unfavorable pre-service reconsiderations are processed timely.	Closed

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Samaritan Health Services	1-541-768-4119	H3811	MA	Audit Findings	10/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	1. The MAO will be required to submit a new universe and sample case files for Unfavorable Standard Pre Service Reconsiderations. 2. Policies and procedures must be developed or revised to map the workflow in a clear, detailed manner, outlining each step, task, responsibility as well as timeline to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director) if those departments are involved in the process. 3. The MAO must develop internal controls to ensure that unfavorable pre-service reconsiderations are effectuated timely.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	The MAO must ensure that all marketing materials include the material identification number and CMS approval date. The MAO must provide CMS with documentation to show that the current training materials being used to train marketing representatives as well as the grievance letter have been submitted to and approved by CMS. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance with CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO must establish and maintain effective oversight over its marketing representatives. The MAO must develop and implement a more thorough tracking system, which includes the type of training available, frequency of training and re-testing, scores are achieved on the testing modules, and internal controls to better monitor the overall training of the sales force. The MAO must track performance data. The MAO must revise internal policies and procedures to reflect and ensure that documentation is maintained in the representatives' files. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office the details and the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	The MAO must notify the member of its grievance decision timely. The MAO must evaluate and implement its policies and procedures related to grievances. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	The MAO must issue compliant grievance notices. The MAO must provide CMS with documentation to show that it is using a grievance notice that meets CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	The MAO must enhance its oversight controls over its delegated entity to ensure that delegated entity "P" makes correct claim determinations. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements. Beginning with the 4th Quarter of 2007, the MAO must evaluate the delegated entity's claims process to ensure that appropriate determinations are made. The MAO must send the regional office a summary report of its findings. This report is due to the regional office within 15 days of the close of the quarter. The MAO will be required to submit this quarterly report until further notified.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must enhance its oversight controls its delegated entities to ensure that clean claims are paid timely and interest is appropriately calculated and paid for clean claims that are not paid timely. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements. Beginning with the 4th Quarter of 2007, the MAO must evaluate the delegated entities' claims process to ensure that non-contracted provider claims are paid timely and interest is appropriately calculated and paid, as applicable. The MAO must send the regional office a summary report of its findings. This report is due to the regional office within 15 days of the close of the quarter. The MAO will be required to submit this quarterly report until further notified.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The MAO must enhance its oversight controls over its delegated entity to ensure that delegated entity "P" adjudicates non-clean claims timely. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements. Beginning with the 4th Quarter of 2007, the MAO must evaluate the delegated entity's claims process to ensure that non-clean claims are processed timely. The MAO must send the regional office a summary report of its findings. This report is due to the regional office within 15 days of the close of the quarter. The MAO will be required to submit this quarterly report until further notified.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must ensure that delegated entity "P" issues compliant written denial notices. The MAO must provide CMS with documentation to show that the delegated entity is using a denial notice that meets CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The MAO must make an adverse standard pre-service organization determination timely. The MAO must evaluate and implement its policies and procedures related to pre-service organization determination. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO must issue compliant denial notices. The MAO must provide CMS with documentation to show that it is using a denial notice that meets CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The MAO must decide whether to expedite an organization determination promptly, including providing the extension notice timely. The MAO must evaluate and implement its policies and procedures for handling requests for expedited organization determination. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	The MAO must send the Detailed Explanation of Non-Coverage notice timely. The MAO must evaluate and implement its policies and procedures related to the detailed explanation of non-coverage of provider services. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MAO must process favorable claims reconsiderations timely. The MAO must evaluate and implement its policies and procedures related to favorable claims reconsiderations. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	The MAO must process adverse claims reconsiderations timely. The MAO must evaluate and implement its policies and procedures related to adverse claims reconsiderations. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	The MAO must process adverse standard pre-service reconsiderations timely and appropriately, including sending the case to the IRE. The MAO must evaluate and implement its policies and procedures related to adverse standard pre-service reconsiderations. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA	Audit Findings	10/1/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	The MAO must decide whether to expedite a reconsideration promptly. The MAO must evaluate and implement its policies and procedures for handling requests for expedited reconsideration. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must provide to CMS a strategy, (i.e., a timeline with goals for implementation and accomplishment), that describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Freedom Health must revise its policies and procedures regarding notifying authorized prescribers, network pharmacies, and pharmacists of negative formulary changes (RX08) to contain the required provisions: - to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes at least 60 days prior to the date the change becomes effective, and - to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Freedom Health must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing (MAPM-9) to include the required provisions: - a provision to conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines, - a requirement that all persons marketing on behalf of Freedom Health be state licensed, certified or registered individuals, and - a requirement that any person directly employed or contracted to market on behalf of Freedom Health provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide documentation to CMS demonstrating that it's Marketing Program monitoring activities confirm that Freedom Health's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Freedom Health must also provide CMS with evidence that it has a current contract/compensation structure in effect for persons conducting marketing for its Part D plans that includes the following provisions: - any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal health care laws (including civil monetary penalty laws), - requiring any person directly employed or contracted to market on behalf of Freedom Health provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with Freedom Health. The person may be compensated based on your enrollment in a plan.' - a compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans, - a person/agency performing marketing to beneficiaries is prohibited from making payments to beneficiaries, and - payment will be withheld or withdrawn if an enrollee disenrolls in an unreasonably short time frame. Freedom Health must also ensure that all individual performing marketing are state licensed, certified, or registered. Freedom Health must provide CMS with a copy of the language in the contract/compensation structures and inform CMS when all contract/compensation structures are issued and in effect.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Freedom Health must revise its policies and procedures regarding beneficiary notification of formulary changes to include a provision to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Freedom Health must revise its policies and procedures for providing notification of formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage (RX06) to include a provision with a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	Freedom Health must develop a system to track and provide reports regarding Freedom Health's transition process utilization for LTC residents and provide documentation demonstrating this to CMS. This documentation must demonstrate to CMS that Freedom Health correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements, as well as the ability to document that Freedom Health has and implements a transition process that covers an emergency supply or `first fill' of non-formulary Part D drugs.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 09: Coordination of Benefits/True Out of Pocket Costs	TrOOP Status at Disenrollment - The Part D sponsor must provide the beneficiary¿s true out-of-pocket (TrOOP) status to the beneficiary as of the effective date of disenrollment.	Freedom Health submitted to the auditors a policy and procedure (Part D Coordination of Benefits) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Freedom Health must provide documentation to CMS that demonstrates Freedom Health has developed and implemented procedures to conduct ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception and more specifically that Freedom Health's network pharmacies meet the requirement for posting or distributing notices. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Freedom Health must revise its policies and procedures (GA 6.1 Coverage Determination and Redeterminations, Medicare Part D) to include the following: - provisions for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing, - a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee's appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee, and - the definition of a coverage determination in accordance with § 423.566(b)(1-5). Specifically, the following actions must be considered coverage determinations by Freedom Health: - A decision not to provide or pay for a Part D drug (including a decision not to pay because the drug is not on Freedom Health's formulary, because the drug is determined not to be medically necessary, because the drug is furnished by an out-of-network pharmacy, or because Freedom Health determines that the drug is otherwise excludable) that the enrollee believes may be covered by the plan - Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the enrollee, - A decision concerning an exceptions request regarding a plan's tiered cost-sharing structure, - A decision concerning an exceptions request regarding a non-formulary drug. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must revise its `Call Log' to have the ability to track and address in a timely manner enrollees' oral and written requests for exceptions, coverage determinations, and redeterminations. Specifically, this system must be able to demonstrate that it tracks, at a minimum, the date of notification, disposition of the request, and date of disposition. Freedom Health must provide documentation demonstrating this to CMS.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Freedom Health must revise its policies and procedures (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to include the following provisions in their entirety: - failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring Freedom Health to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - Freedom Health must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-CD1_D, Standard Coverage Determinations Concerning Drug Benefits, contained misclassified cases. Based on the analysis, Freedom Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Freedom Health must revise its policies and procedures regarding enrollee notification of coverage determinations concerning payment to contain: - a provision stating that Freedom Health must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, `or, for an exceptions request, after receiving the physician's supporting statement', - a provision stating that Freedom Health must authorize payment and notify the enrollee within 72 hours after receiving the request, `or, for an exceptions request, after receiving the physician's supporting statement', - a provision stating that Freedom Health must make payment (i.e., mail the payment) within 30 calendar days of the request, `or, for an exceptions request, after receiving the physician's supporting statement', and - provisions stating that failure to notify the enrollee within the timeframe `constitutes an adverse determination' requiring Freedom Health to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to policy GA6.1 `Coverage Determination and Redeterminations, Medicare Part D'. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Freedom Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-CD1_D, Standard Coverage Determinations Concerning Drug Benefits, contained misclassified cases. Based on the analysis, Freedom Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Freedom Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Freedom Health must revise its policies and procedures regarding decisions to accept or deny requests for expedited coverage determinations to discuss the means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, Freedom Health must develop a procedure to process expedited coverage determination requests when a request is received over the weekend that complies with CMS regulations.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Freedom Health must revise its policy GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D' to include the following: - a provision stating that Freedom Health must make its expedited coverage determination and notify the enrollee `(and/or other applicable party)' of its decision (adverse or favorable), `as expeditiously as the enrollee's health condition requires', but no later than 24 hours after receiving the request, `or, for an exceptions request, the physician's supporting statement', and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse determination' requiring Freedom Health to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added. Additionally, the term `expedited coverage determination' must be added to policy GA6.1 under the section entitled `Failure to Provide Timely Notice'. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Freedom Health must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Freedom Health must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to include the following: - a provision stating that if Freedom Health makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - a provision stating that Freedom Health must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - a provision stating that if Freedom Health is waiting on a physician's statement in support of a tiering exception request, Freedom Health must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Freedom Health must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to include provisions stating that: - if Freedom Health makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - Freedom Health must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement - if Freedom Health is waiting on a physician's statement in support of a formulary exception request, it must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Freedom Health must revise its policies and procedures regarding determining cost-sharing for approved exceptions to include: - a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and - a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-CD1_D, Standard Coverage Determinations Concerning Drug Benefits, contained misclassified cases. Based on the analysis, Freedom Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Freedom Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Freedom Health must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Acceptable documentation would include copies of phone scripts or the notice template for informing enrollees of complaint categorization. Freedom Health must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Freedom Health does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Freedom Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide documentation to CMS demonstrating that it has developed and implemented a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-CD1_D, Standard Coverage Determinations Concerning Drug Benefits, contained misclassified cases. Based on the analysis, Freedom Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Freedom Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Freedom Health must demonstrate, and provide documentation of this to CMS, that its grievances system has a means for ensuring the timely resolution of enrollee grievances. The `Call Log' must be modified to include fields to track: mode of receipt of grievance, entity that filed the grievance, disposition of the grievance, and the date the enrollee was notified of grievance resolution.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Freedom Health must notify enrollees of grievance resolution, and document this notification, within the CMS-approved timeframe, and provide CMS documentation of this.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Freedom Health must always notify the enrollee of grievance resolution and provide documentation demonstrating this to CMS.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Freedom Health must revise its `Call Log' system to be able to track whether a request was submitted in writing or filed within 60 days of the notice of the coverage determination and provide documentation demonstrating this to CMS.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Freedom Health must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to include a provision stating that any additional medical information Freedom Health requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Freedom Health must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Freedom Health to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with a CMS-approved notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'). If Freedom Health does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Freedom Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Standard Redeterminations concerning Drug Benefits, contained misclassified samples. Based on the analysis, Freedom Health must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Freedom Health must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Freedom Health to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with a CMS-approved notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'). If Freedom Health does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Freedom Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Freedom Health must revise its policies and procedures regarding enrollee notification following decision on expedited redetermination and requesting medical information required for making a decision on an expedited redetermination (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to: - state that medical information must be requested within 24 hours of the enrollee¿s initial request, and - include provisions stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Freedom Health to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with a CMS-approved notice for requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'). If Freedom Health does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Freedom Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Freedom Health must modify its system for expedited coverage determination reversals to have the capacity for tracking timeliness and provide documentation demonstrating this to CMS.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Freedom Health must revise its policies and procedures regarding personnel conducting redeterminations (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to include a provision stating that if the issue is a denial based on lack of medical necessity, then Freedom Health must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Standard Redeterminations concerning Drug Benefits, contained misclassified samples. Based on the analysis, Freedom Health must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Corrective Action Required: Freedom Health must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (GA 6.1 `Coverage Determination and Redeterminations, Medicare Part D') to state that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. Freedom Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Standard Redeterminations concerning Drug Benefits, contained misclassified samples. Based on the analysis, Freedom Health must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open
Freedom Health, Inc	1-813-506-6107	H5427	MA-PD	Audit Findings	10/1/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Freedom Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Standard Redeterminations concerning Drug Benefits, contained misclassified samples. Based on the analysis, Freedom Health must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA-PD	Audit Findings	9/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	The Part D sponsor must develop internal policies and procedures, and work with Medco to update its policies and procedures, to clarify the roles between the two entities with respect to notifying beneficiaries of coverage determinations. Refer to the Prescription Drug Benefit Manual, Chapter 18, Sections 30 and 40, and Appendix 1. The sponsor and Medco must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The sponsor needs to submit the notice to CMS for approval through HPMS if it does not already have an approved coverage determination notice. The Part D sponsor must monitor its delegated entities' activities, in this case Medco, and provide to CMS a description of how and when the monitoring will take place. The sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA-PD	Audit Findings	9/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	The Part D sponsor must develop internal policies and procedures, and work with Medco to update its policies and procedures, to clarify the roles between the two entities with respect to notifying beneficiaries of coverage determinations. Refer to the Prescription Drug Benefit Manual, Chapter 18, Sections 30 and 40, and Appendix 1. The sponsor and Medco must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The sponsor needs to submit the notice to CMS for approval through HPMS if it does not already have an approved coverage determination notice. The Part D sponsor must monitor its delegated entities' activities, in this case Medco, and provide to CMS a description of how and when the monitoring will take place. The sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	9/27/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	The MAO must conduct training of appropriate staff on the correct procedures to follow when identifying and submitting File and Use materials to CMS. Submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The corrective action plan must include a detailed description of the steps the MAO is taking to ensure compliance with these requirements.	Closed
Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	9/27/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	The MAO must review its website and every link to determine what needs corrected and which documents are out-of-date. The CAP must include: 1) the problems identified, 2) details of how the problems will be resolved with a timeline, and 3) what steps the MAO is taking to ensure compliance in the future.	Closed

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Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	9/27/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO must review its Policy 038.01 Marketing Requirements.doc to determinine if it describes the types of audits the MAO will conduct to confirm that members understand the rules applicable under the plan they enrolled in. If appropriate, revise the Policy and submit it for CMS review. The CAP must include a detailed description of the types and numbers of audits the MAO will conduct, a timeline for completing the audits, and a plan for sharing the audit results with CMS.	Closed
Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	9/27/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO must review its Policy 038.01 Marketing Requirements.doc to decide if it describes the types of agents/brokers audits the MAO will conduct to determine if they are engaging in activities which materially mislead, confuse, or misrepresent the MAO. If appropriate, revise the Policy and submit it for CMS review. The MAO also should consider auditing the accuracy of the agents/brokers enrollment applications. The CAP must include a detailed description of: 1) the MAO's oversight of the agents/brokers activities, 2) the types and numbers of audits the MAO will conduct, 3) a timeline for the audits, and 4) the plan for sharing the audit results with CMS.	Closed
Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	9/27/2007	Closed	Chapter 06 - Provider Relations	Participation and Termination Procedures - The MAO must have written policies and procedures and a process for rules of physician participation and adverse participation decisions.	The MAO must develop or update existing written internal rules of participation for physicians that include terms of payment. Policies and procedures must be updated to include: 1) the MAO gives written notice of material rule changes before the rules are put into effect, and 2) the MAO notifies contracting physicians of the timeframes for terminating the contract without cause within at least 60 days of the termination. The MAO must assure that the language in the contracts adheres to the policy. The MAO must review, finalize and implement its policy and procedure for Opt-Out Providers. New/updated documents must be submitted to CMS. The MAO must conduct training of appropriate staff on the new/updated policies and procedures. Submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The CAP must include a detailed description of the steps the MAO is taking to ensure compliance with these requirements.	Closed

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Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	9/27/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	The MAO must conduct training of appropriate staff and delegated entities on how to utilize QI information during the recredentialing process. Submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must perform monthly internal audits of its universe of recredentialing files each month for October, November and December 2007, with the results submitted to the CMS Regional Office by the 7th day of the following month. The audits are to determine whether the QI information is being utilized. The CAP must include a detailed description of the steps the MAO is taking to ensure compliance with CMS' instructions.	Closed
Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	9/27/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	The MAO must execute an amendment which includes the required language with all contracted first tier and downstream entities. A copy of the amendment must be submitted to the CMS Regional Office. The corrective action plan (CAP) needs to contain the MAO's detailed plans for obtaining the amendments, including how many contract amendments are required and when the MAO expects to receive the amendments. Monthly progress reports are due to the CMS Regional Office beginning November 15, 2007.	Closed
Covenant Health System - Hendrick Health System	1-512-257-6348	H4525	MA	Audit Findings	9/27/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO must conduct training of appropriate staff on the correct procedures: 1) to identify standard pre-service denials, 2) to notify the beneficiary of a pre-service denial, and 3) on how to properly document the case file. Submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The MAO must perform monthly internal audits of its universe of pre-service denial cases each month for October, November and December 2007, with the results submitted to the CMS Regional Office by the 7th day of the following month. The audits are to determine whether the MAO is notifying the enrollee of its decision to deny the service as required by regulation. The CAP must include a detailed description of the steps the MAO is taking to ensure compliance with the notification requirements and to ensure that each case file is properly documented.	Closed
XLHealth Corporation	1-410-735-8768	H5665	MA	Audit Findings	9/19/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Care Improvment Plus must establish and maintain a system for confirming that enrolled members are enrolled in the MA plan and that they understand the rules applicable under the plan.	Closed

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XLHealth Corporation	1-410-735-8768	H5665	MA	Audit Findings	9/19/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Care Improvement Plus must establish a mechanism which will ensure that neither plan employees or agents acting on behalf of the plan are engaging in activities which materially mislead, confuse or misrepresent the MAO.	Closed
XLHealth Corporation	1-410-735-8768	H5665	MA	Audit Findings	9/19/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Care Improvment Plus must ensure that all provider contracts contain language which includes CMS requirements that records be maintained for ten years.	Closed
XLHealth Corporation	1-410-735-8768	H5665	MA	Audit Findings	9/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Care Improvement Plus must ensure that all claims are being processed following CMS requirements. The plan must demonstrate mechanisms and processes for oversight of its delegated vendors.	Closed

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XLHealth Corporation	1-410-735-8768	H5665	MA	Audit Findings	9/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Care Improvement Plus must ensure that all notices sent to members are in compliance with Medicare requirements. Care Improvement Plus must provide evidence that it is conducting appropriate oversight of its delegated vendors.	Closed
XLHealth Corporation	1-410-735-8768	H5665	MA	Audit Findings	9/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Care Improvement Plus must have mechanisms in place to ensure that it notifies the member in writing, using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than fourteen days after receiving the request(or an additional fourteen days if an extension is justified).	Closed
XLHealth Corporation	1-410-735-8768	H5665	MA	Audit Findings	9/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Care Improvement Plus must have in place mechanisms to ensure that if they make a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than fourteen calendar days after receiving the request (or an additional fourteen days if an extension is justified).	Closed
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA	Audit Findings	9/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	1. Medica HealthCare Plans, Inc. must request a corrective action plan from the delegated entity for this finding and submit it to CMS. 2. Medica HealthCare Plans, Inc. must provide CMS with a quarterly report of its monitoring results of the delegated entity¿s performance related to this requirement. A quarterly report is required until a sustained improvement is demonstrated.	Closed
Medica HealthCare Plans, Inc.	1-305-460-0618	H5420	MA	Audit Findings	9/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	According to Medica HealthCare Plans, Inc., they do not have a representative universe of unfavorable claims reconsiderations for the audit time span of February thru July 2007. The MAO is required to submit a representative universe for RC02 as soon as a universe is available. For the purposes of this corrective action request, a universe of 5 cases will be considered adequate.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Mid Rogue Health Plan must create policies and procedure for providing notice regarding formulary changes that contain the following provisions: - to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes at least 60 days prior to the date the change becomes effective, and - to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Additionally, the policy and procedure must include a description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on Mid Rogue Health Plan's Internet website. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Mid Rogue Health Plan must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to include a requirement that any person directly employed or contracted to market on behalf of Mid Rogue Health Plan provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with documentation that its marketing program monitoring activities confirm that Mid Rogue Health Plan's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of a field evaluation tool or Agent Checklist. Mid Rogue Health Plan must also provide CMS with evidence that it has a current contract/compensation structure in effect for persons conducting marketing for its Part D plans that includes the following provisions: -any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal health care laws (including civil monetary penalty laws), -requiring any person directly employed or contracted to market on behalf of Mid Rogue Health Plan provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Mid Rogue Health Plan. The person may be compensated based on your enrollment in a plan.' -a compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans, -a person/agency performing marketing to beneficiaries is prohibited from making payments to beneficiaries, and -payment will be withheld or withdrawn if an enrollee disenrolls in an unreasonably short time frame. Mid Rogue Health Plan must also ensure that all individual performing marketing are state licensed, certified, or registered. Mid Rogue Health Plan must provide CMS with a copy of the language in the contract/compensation structures and inform CMS when all contract/compensation structures are issued and in effect.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, Mid Rogue Health Plan must ensure that it provides a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. Mid Rogue Health Plan must provide documentation to CMS demonstrating that it provides written notice to affected enrollees at least 60 days prior to the change, or provides an affected enrollee with a 60-day supply of the drug under the same terms as well as written notice of the formulary change at the time a refill of the drug is requested.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Mid Rogue Health Plan must create policies and procedure for providing notice regarding formulary changes that contain the following: - a provision with a description of the procedures for providing a notice of 'maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, - a provision with a description of the procedures for providing a notice of 'other' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. Additionally, the policy and procedure must include a description of the method(s) used to provide notification of formulary changes. Notification method(s) must include, at a minimum, posting formulary changes on Mid Rogue Health Plan's Internet website. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Mid Rogue Health Plan must create policies and procedures regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception. This policy must include: - a provision for arranging with its network pharmacies to post or distribute the 'Medicare Prescription Drug Coverage and Your Rights' notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist, and - a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices. Or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Mid Rogue Health Plan must create policies and procedures regarding reporting requirements for appeals data elements that include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Mid Rogue Health Plan must revise its PD002 Standard Drug Coverage Process policy and procedure to include the following provisions: -Mid Rogue Health Plan must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement, and -failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring Mid Rogue Health Plan to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Mid Rogue Health Plan must create policies and procedures regarding enrollee notification of coverage determinations concerning payment that include the required provisions: -Mid Rogue Health Plan must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -Mid Rogue Health Plan must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, -Mid Rogue Health Plan must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and -failure to notify the enrollee within the timeframe constitutes an adverse determination requiring Mid Rogue Health Plan to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Mid Rogue Health Plan makes an adverse standard coverage determination concerning drug benefit decision, it must always notify the enrollee of its decision, as well as use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Mid Rogue Health Plan must revise is Policy PD004 Expedited Coverage Process to state: - Mid Rogue Health Plan must grant a request for an expedited determination if it determines, based on the enrollee's request, or as indicated in the prescribing physician's request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, and - all oral requests must be documented in writing and that documentation of the request must be maintained in a case file. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Mid Rogue Health Plan must revise its PD004 Expedited Coverage Process document to state that if Mid Rogue Health Plan denies a request to expedite a coverage determination, it must automatically transfer the request to the standard coverage determination process, `give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice'. Specifically, the language in quotation marks must be added. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Mid Rogue Health Plan must revise its PD004 Expedited Coverage Process policy to include provisions stating that both oral and written notice must: - inform the enrollee of the right to file an expedited grievance, - inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and - provide instructions about Mid Rogue Health Plan's grievance process and its timeframes. Additionally, the policy must include a provision that `oral and' written notice must provide an explanation that Mid Rogue Health Plan must process the request using the 72 hour timeframe for standard determinations. Specifically, the language in quotation marks must be added. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for notifying the enrollee that a request for an expedited coverage determination is denied (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Mid Rogue Health Plan must revise its PD004 Expedited Coverage Process policy to include provisions stating that: - if the decision is adverse and Mid Rogue Health Plan first notifies the enrollee of the determination orally, Mid Rogue Health Plan must mail written confirmation to the enrollee within 3 calendar days of the oral notification, - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring Mid Rogue Health Plan to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe, and - Mid Rogue Health Plan must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Mid Rogue Health Plan must revise its PD004 Expedited Coverage Process policy to include provisions stating that: -if the decision is adverse, then Mid Rogue Health Plan must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, and -if oral notice is provided for adverse decision, the notices must satisfy the following requirements: -state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, -provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and -provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Mid Rogue Health Plan must revise its policy PD003 to include provisions stating that: -Mid Rogue Health Plan must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and -if Mid Rogue Health Plan is waiting on a physician's statement in support of a tiering exception request, Mid Rogue Health Plan must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Mid Rogue Health Plan must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs to include: -a provision stating that Mid Rogue Health Plan must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, -a provision stating that if Mid Rogue Health Plan is waiting on a physician's statement in support of a formulary exception request, Mid Rogue Health Plan must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception, and -a provision stating that Mid Rogue Health Plan must grant a formulary exception when it determines that one of the three factors (detailed below) has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. (1) All covered Part D drugs on any tier of Mid Rogue Health Plan 's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for requesting additional information from the enrollee's prescribing physician (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Request for Additional Information'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Mid Rogue Health Plan must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Mid Rogue Health Plan must add a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary, to its PD Grievance Procedure policy. Mid Rogue Health Plan must revise its PD Grievance Procedure policy to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Mid Rogue Health Plan must revise its PD Grievance Procedure policy to include provisions stating: -all concerned parties must be notified of grievance disposition as expeditiously as the enrollees case requires, based on the enrollees health status, but not later than 30 days after Mid Rogue Health Plan receives the oral or written grievance, -the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if Mid Rogue Health Plan justifies a need for additional information and documents how the delay is in the interest of the enrollee, and -the enrollee must immediately be notified in writing when Mid Rogue Health Plan extends the deadline. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for informing enrollees of grievance deadline extension (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must notify enrollees of grievance resolution within the CMS-approved timeframe, and provide documentation demonstrating this to CMS.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Mid Rogue Health Plan must revise its PD Grievance Procedure policy document to include provisions that state: -all grievances submitted in writing must be responded to in writing, and -grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plans Decision Regarding a Grievance). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Plans Decision Regarding a Grievance), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must always notify the enrollee of grievance resolution. Additionally, when a grievance is responded in writing, Mid Rogue Health Plan must use a notice consistent with CMS-issued model notice, Notice of Plans Decision Regarding a Grievance. Mid Rogue Health Plan must provide documentation demonstrating this to CMS.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Mid Rogue Health Plan must provide CMS with a CMS-approved notice for notification of grievance disposition (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Plan's Decision Regarding a Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	Mid Rogue Health Plan must revise its PD Grievance Procedure policy to include a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by Mid Rogue Health Plan to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Mid Rogue Health Plan must revise its PD008 Standard Redetermination Process policy to include a provision for accepting written requests for standard redeterminations of coverage determinations filed by enrollees within 60 calendar days of the notice of the coverage determination. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Mid Rogue Health Plan must revise its policy PD 007 Expedited Re-determination Process to include a provision stating that Mid Rogue Health Plan automatically expedites a request when the enrollee's physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	Mid Rogue Health Plan must revise its policy PD007 Expedited Re-determination Process to include a provision stating that Mid Rogue Health Plan must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with a CMS-approved notice for notifying the enrollee that a request for an expedited redetermination is denied (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Mid Rogue Health Plan must revise its policy PD008 Standard Redetermination Process to include the following: - a provision stating that Mid Rogue Health Plan must inform the enrollee, within 24 hours, when the case is forwarded to the IRE, - a provision for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Mid Rogue Health Plan to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with CMS-approved notices for: notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'), requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'), and enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., notices consistent with the CMS-issued model notices, `Notice of Redetermination',`Request for Reconsideration', and `Notice of Case Status', respectively), then it must submit these for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must be able to demonstrate, and provide documentation of this to CMS, the date the member was notified in writing of the initial coverage determination regarding drug benefit denial, the date the standard redetermination concerning drug benefit request was received, that the redetermination decision was made timely, and that in all cases when a standard redetermination concerning drug benefit decision is untimely, the case file is forwarded to the IRE as required.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Mid Rogue Health Plan must revise its policy PD008 Standard Redetermination Process to include the following: - for redeterminations favorable to the enrollee, Mid Rogue Health Plan must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Mid Rogue Health Plan to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Mid Rogue Health Plan must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with CMS-approved notices for: notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'), requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'), and enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., notices consistent with the CMS-issued model notices, `Notice of Redetermination', `Request for Reconsideration', and `Notice of Case Status', respectively), then it must submit these for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Mid Rogue Health Plan must revise its policy PD007 Expedited Redetermination Process to include the following: - a provision stating that Mid Rogue Health Plan must notify the enrollee (and the prescribing physician involved, as appropriate) of its redetermination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after it received the request for an expedited redetermination, - a provision indicating that initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, - a provision stating that failure to notify the enrollee of the redetermination decision within the timeframe constitutes an adverse redetermination decision requiring Mid Rogue Health Plan to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Mid Rogue Health Plan must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must provide CMS with CMS-approved notices for: notifying enrollees of an adverse standard redetermination (i.e., a notice consistent with the CMS-issued model notice, `Notice of Redetermination'), requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, `Request for Reconsideration'), and enrollee notification when a request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, `Notice of Case Status'). If Mid Rogue Health Plan does not have a notice template that has been approved by CMS (i.e., notices consistent with the CMS-issued model notices, `Notice of Redetermination', `Request for Reconsideration', and `Notice of Case Status', respectively), then it must submit these for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Mid Rogue Health Plan must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Mid Rogue Health Plan must revise its policies PD007 and PD008 to include: - a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination, and - a provision stating that if the issue is a denial based on lack of medical necessity, then Mid Rogue Health Plan must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Mid Rogue Health Plan must demonstrate, and provide documentation of this to CMS, that the person making the initial coverage determination decision is not the person making the redetermination decision. Mid Rogue Health Plan must provide documentation to CMS demonstrating that Mid Rogue Health Plan uses appropriate personnel to conduct redeterminations. Specifically, the person involved in making the initial coverage determination decision must not be the same person making the redetermination decision. Additionally, when the initial coverage determination denial is based on a lack of medical necessity, as defined in Chapter 18 of the Prescription Drug Benefit Manual, the redetermination must be performed by a physician with expertise in the field of medicine that is appropriate for the benefits at issue.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Mid Rogue Health Plan must revise its policies PD007 and PD008 to contain the following: - case files must be sent the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file, and - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Mid Rogue Health Plan must create policies and procedures for effectuating third party reversals on an appeal of a request for benefit that include the following: - the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision, and - a provision requiring a notice to be sent informing the IRE of the effectuation. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Mid Rogue Health Plan must create policies and procedures for effectuating third party reversals on an appeal of a request for payment that include the following: - a provision stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision, - a provision stating that payment must be made no later than 30 days from the date it receives notice reversing the decision, and - a provision requiring a notice to be sent informing the IRE of the effectuation. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Mid Rogue Community Health Plan	1-541-471-4106	H3810	MA-PD	Audit Findings	9/17/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Mid Rogue Health Plan must create policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit that contain the following: - the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision, and - a provision requiring a notice to be sent informing the IRE of the effectuation. Mid Rogue Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Create and standardize a documented process for all 5 states to ensure all regions are completing initial credentialing and recredentialing, and compiling information in the same manner. Create a checklist for compiling documentation that must be included in the credentialling file and then centralize the documentation for easier access. Rules in the Standard Operating Procedure are very clear of what must be contained in the credentialling file and how information should be obtained. Document the new process in Policy and Procedures to indicate there is a standardized and centralized documentation process for meeting provider credentialing requirements and submit for CMS review.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Create and standardize a process for each state that is similar to the documentation process that is currently being used in Utah to ensure that facilities in all 5 states are being credentialed and monitored unilaterally. Incorporate the new policy and procedure into MA-PRV-01 to ensure continuity and submit for CMS review. Recommend centralized documentation for all 5 states.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Molina must revise its policies and procedures (P and P) to establish proper claims determinations. There could be multiple reasons for denying a claim, however, policies need to be established to identify proper denials. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina must establish a P and P to ensure that claims are being processed by the proper component. Pharmacy claims that are not covered under traditional Medicare should be re-directed to Molina's Part D claims processor. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina should establish a P and P to ensure that claims that are either referred by, or performed by an authorized Molina provider are processed and paid if they meet the criteria for coverage. Molina should conduct training of appropriate staff, including participating providers, on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina should conduct an internal audit each month of denied claims. This audit should evaluate whether claims are being properly denied, processed timely, and whether proper denial language is included in the notices. Please submit a summary report once a quarter beginning December 31, 2007 to the regional office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	1. All outpatient claims should be paid in accordance with Medicare guidelines. The Part A deductible should only be applied to inpatient claims and should not be applied to outpatient claims. There could be Medicare Advantage Organization (MAO) must develop and implement procedures that will ensure the accuracy of the payment for all outpatient claims as well as the accuracy of any copayment amounts or deductibles that are withheld. 2. Remittance advices for some States show the copayment amount that was withheld for the claim. However, there were remittance advices that did not reflect any copayment amount withheld even though there was a copayment amount that was withheld. It is recommended that the MAO should standardize all remittance advices to reflect the same data elements to ensure consistency in provider notifications. 3. The MAO should implement a process of updating payment amounts to ensure that claims are always paid based on the correct fee schedule amount for any given year.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Molina must ensure that non-contracting providers' clean claims are paid timely. 95% of clean claims are required to be paid within 30 days of receipt. Molina must submit a corrective action plan (CAP) that will ensure that it processes non-participating providers' claims on a timely basis. The plan must include how it will monitor that non-participating provider claims are paid timely. Molina must conduct training of appropriate staff on the payment of 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt. For the CAP to be released, Molina must demonstrate that at least 95% of the non-participating provider claims are paid within 30 days for 2 consecutive quarters. Molina must establish a policy and procedure (P and P) to ensure that claims are logged into the system with an accurate receipt date and that the log date and control date are the same. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance. During the review of the sample claims for this element, it became apparent that Molina has inconsistent methods for handling claims processing. One example is that checks to providers are mailed the day after the claim is adjudicated in Utah, yet three days later for another state. Although some differnces are inevitable due to Medicaid differences in each state, it is highly recommended that Molina standardize as many claims processes as possible. Therefore, CMS recommends that as many claim processes as possible be standardized to follow the processes established for the state of Utah.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Because the one claim was only pennies less on the interest amount, the Medicare Advantage Organization (MAO) does not need to adjust this claim to pay the correct interest. However, on the claim where interest was not paid, the MAO should adjust the claim to pay interest. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by December 31, 2007.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The Medicare Advantage Organization (MAO) must revise its policies and procedures to ensure that non-clean claims are processed timely. Conduct training of appropriate staff on the revised Policy and Procedure and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Molina must establish policies and procedures (P and P) to ensure that a denial notice is issued each time a claim is denied. Molina must conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina should conduct an internal audit each month of denied claims. This audit should evaluate whether claims are being properly denied, processed timely, and whether denial notices with proper denial language are being issued. Please submit a summary report once a quarter beginning December 31, 2007, to the Regional Office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	If Molina makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or a Regional Office-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason. Molina must submit a corrective action plan, describing the actions they will take to assure that they are using the CMS approved NDMC. Provide a timeline when the CMS approved NDMC will be fully adopted.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5588	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Molina must develop policies and procedures (P and P) so that when a member requests a service that requires prior authorization, whether in writing or via the telephone, the provider should be contacted by Molina and directed to submit the pre-authorization request. Molina will also need to document the member and provider requests and track whether or not the provider has followed through on Molina's request. This change in Molina's approach to prior authorizations will also require modification of Molina's provider manual and other provider instructions regarding prior authorizations. Molina should conduct training of appropriate staff on the new P and P. Molina will a lso need to conduct training of its contracted providers in order for them to understand the new process. Molina must submit a corrective action plan (CAP) for this element that includes the new P and P and details of the training it plans to conduct on those P and Ps.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Create and standardize a documented process for all 5 states to ensure all regions are completing initial credentialing and recredentialing, and compiling information in the same manner. Create a checklist for compiling documentation that must be included in the credentialling file and then centralize the documentation for easier access. Rules in the Standard Operating Procedure are very clear of what must be contained in the credentialling file and how information should be obtained. Document the new process in Policy and Procedures to indicate there is a standardized and centralized documentation process for meeting provider credentialing requirements and submit for CMS review.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Molina must revise its policies and procedures (P and P) to establish proper claims determinations. There could be multiple reasons for denying a claim, however, policies need to be established to identify proper denials. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina must establish a P and P to ensure that claims are being processed by the proper component. Pharmacy claims that are not covered under traditional Medicare should be re-directed to Molina's Part D claims processor. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina should establish a P and P to ensure that claims that are either referred by, or performed by an authorized Molina provider are processed and paid if they meet the criteria for coverage. Molina should conduct training of appropriate staff, including participating providers, on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina should conduct an internal audit each month of denied claims. This audit should evaluate whether claims are being properly denied, processed timely, and whether proper denial language is included in the notices. Please submit a summary report once a quarter beginning December 31, 2007 to the regional office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	1. All outpatient claims should be paid in accordance with Medicare guidelines. The Part A deductible should only be applied to inpatient claims and should not be applied to outpatient claims. The Medicare Advantage Organization (MAO) must develop and implement procedures that will ensure the accuracy of the payment for all outpatient claims as well as the accuracy of any copayment amounts or deductibles that are withheld. 2. Remittance advices for some States show the copayment amount that was withheld for the claim. However, there were remittance advices that did not reflect any copayment amount withheld even though there was a copayment amount that was withheld. It is recommended that the MAO should standardize all remittance advices to reflect the same data elements to ensure consistency in provider notifications. 3. The MAO should implement a process of updating payment amounts to ensure that claims are always paid based on the correct fee schedule amount for any given year.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Molina must ensure that non-contracting providers' clean claims are paid timely. 95% of clean claims are required to be paid within 30 days of receipt. Molina must submit a corrective action plan (CAP) that will ensure that it processes non-participating providers' claims on a timely basis. The plan must include how it will monitor that non-participating provider claims are paid timely. Molina must conduct training of appropriate staff on the payment of 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt. For the CAP to be released, Molina must demonstrate that at least 95% of the non-participating provider claims are paid within 30 days for 2 consecutive quarters. Molina must establish a policy and procedure (P and P) to ensure that claims are logged into the system with an accurate receipt date and that the log date and control date are the same. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance. During the review of the sample claims for this element, it became apparent that Molina has inconsistent methods for handling claims processing. One example is that checks to providers are mailed the day after the claim is adjudicated in Utah, yet three days later for another state. Although some differnces are inevitable due to Medicaid differences in each state, it is highly recommended that Molina standardize as many claims processes as possible. Therefore, CMS recommends that as many claim processes as possible be standardized to follow the processes established for the state of Utah.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Because the one claim was only pennies less on the interest amount, the Medicare Advantage Organization (MAO) does not need to adjust this claim to pay the correct interest. However, on the claim where interest was not paid, the MAO should adjust the claim to pay interest. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by December 31, 2007.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The Medicare Advantage Organization (MAO) must revise its policies and procedures to ensure that non-clean claims are processed timely. Conduct training of appropriate staff on the revised Policy and Procedure and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	If Molina makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or a Regional Office-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason. Molina must submit a corrective action plan, describing the actions they will take to assure that they are using the CMS approved NDMC. Provide a timeline when the CMS approved NDMC will be fully adopted.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5628	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Molina must develop policies and procedures (P and P) so that when a member requests a service that requires prior authorization, whether in writing or via the telephone, the provider should be contacted by Molina and directed to submit the pre-authorization request. Molina will also need to document the member and provider requests and track whether or not the provider has followed through on Molina's request. This change in Molina's approach to prior authorizations will also require modification of Molina's provider manual and other provider instructions regarding prior authorizations. Molina should conduct training of appropriate staff on the new P and P. Molina will a lso need to conduct training of its contracted providers in order for them to understand the new process. Molina must submit a corrective action plan (CAP) for this element that includes the new P and P and details of the training it plans to conduct on those P and Ps.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Create and standardize a documented process for all 5 states to ensure all regions are completing initial credentialing and recredentialing, and compiling information in the same manner. Create a checklist for compiling documentation that must be included in the credentialling file and then centralize the documentation for easier access. Rules in the Standard Operating Procedure are very clear of what must be contained in the credentialling file and how information should be obtained. Document the new process in Policy and Procedures to indicate there is a standardized and centralized documentation process for meeting provider credentialing requirements and submit for CMS review.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Create and standardize a process for each state that is similar to the documentation process that is currently being used in Utah to ensure that facilities in all 5 states are being credentialed and monitored unilaterally. Incorporate the new policy and procedure into MA-PRV-01 to ensure continuity and submit for CMS review. Recommend centralized documentation for all 5 states.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Molina must revise its policies and procedures (P and P) to establish proper claims determinations. There could be multiple reasons for denying a claim, however, policies need to be established to identify proper denials. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina must establish a P and P to ensure that claims are being processed by the proper component. Pharmacy claims that are not covered under traditional Medicare should be re-directed to Molina's Part D claims processor. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina should establish a P and P to ensure that claims that are either referred by, or performed by an authorized Molina provider are processed and paid if they meet the criteria for coverage. Molina should conduct training of appropriate staff, including participating providers, on the revised P and P and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina should conduct an internal audit each month of denied claims. This audit should evaluate whether claims are being properly denied, processed timely, and whether proper denial language is included in the notices. Please submit a summary report once a quarter beginning December 31, 2007 to the regional office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	1. All outpatient claims should be paid in accordance with Medicare guidelines. The Part A deductible should only be applied to inpatient claims and should not be applied to outpatient claims. There could be Medicare Advantage Organization (MAO) must develop and implement procedures that will ensure the accuracy of the payment for all outpatient claims as well as the accuracy of any copayment amounts or deductibles that are withheld. 2. Remittance advices for some States show the copayment amount that was withheld for the claim. However, there were remittance advices that did not reflect any copayment amount withheld even though there was a copayment amount that was withheld. It is recommended that the MAO should standardize all remittance advices to reflect the same data elements to ensure consistency in provider notifications. 3. The MAO should implement a process of updating payment amounts to ensure that claims are always paid based on the correct fee schedule amount for any given year.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Molina must ensure that non-contracting providers' clean claims are paid timely. 95% of clean claims are required to be paid within 30 days of receipt. Molina must submit a corrective action plan (CAP) that will ensure that it processes non-participating providers' claims on a timely basis. The plan must include how it will monitor that non-participating provider claims are paid timely. Molina must conduct training of appropriate staff on the payment of 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt. For the CAP to be released, Molina must demonstrate that at least 95% of the non-participating provider claims are paid within 30 days for 2 consecutive quarters. Molina must establish a policy and procedure (P and P) to ensure that claims are logged into the system with an accurate receipt date and that the log date and control date are the same. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance. During the review of the sample claims for this element, it became apparent that Molina has inconsistent methods for handling claims processing. One example is that checks to providers are mailed the day after the claim is adjudicated in Utah, yet three days later for another state. Although some differnces are inevitable due to Medicaid differences in each state, it is highly recommended that Molina standardize as many claims processes as possible. Therefore, CMS recommends that as many claim processes as possible be standardized to follow the processes established for the state of Utah.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Because the one claim was only pennies less on the interest amount, the Medicare Advantage Organization (MAO) does not need to adjust this claim to pay the correct interest. However, on the claim where interest was not paid, the MAO should adjust the claim to pay interest. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by December 31, 2007.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The Medicare Advantage Organization (MAO) must revise its policies and procedures to ensure that non-clean claims are processed timely. Conduct training of appropriate staff on the revised Policy and Procedure and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	If Molina makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or a Regional Office-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason. Molina must submit a corrective action plan, describing the actions they will take to assure that they are using the CMS approved NDMC. Provide a timeline when the CMS approved NDMC will be fully adopted.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5810	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Molina must develop policies and procedures (P and P) so that when a member requests a service that requires prior authorization, whether in writing or via the telephone, the provider should be contacted by Molina and directed to submit the pre-authorization request. Molina will also need to document the member and provider requests and track whether or not the provider has followed through on Molina's request. This change in Molina's approach to prior authorizations will also require modification of Molina's provider manual and other provider instructions regarding prior authorizations. Molina should conduct training of appropriate staff on the new P and P. Molina will a lso need to conduct training of its contracted providers in order for them to understand the new process. Molina must submit a corrective action plan (CAP) for this element that includes the new P and P and details of the training it plans to conduct on those P and Ps.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Create and standardize a documented process for all 5 states to ensure all regions are completing initial credentialing and recredentialing, and compiling information in the same manner. Create a checklist for compiling documentation that must be included in the credentialling file and then centralize the documentation for easier access. Rules in the Standard Operating Procedure are very clear of what must be contained in the credentialling file and how information should be obtained. Document the new process in Policy and Procedures to indicate there is a standardized and centralized documentation process for meeting provider credentialing requirements and submit for CMS review.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Create and standardize a process for each state that is similar to the documentation process that is currently being used in Utah to ensure that facilities in all 5 states are being credentialed and monitored unilaterally. Incorporate the new policy and procedure into MA-PRV-01 to ensure continuity and submit for CMS review. Recommend centralized documentation for all 5 states.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	1. All outpatient claims should be paid in accordance with Medicare guidelines. The Part A deductible should only be applied to inpatient claims and should not be applied to outpatient claims. There could be Medicare Advantage Organization (MAO) must develop and implement procedures that will ensure the accuracy of the payment for all outpatient claims as well as the accuracy of any copayment amounts or deductibles that are withheld. 2. Remittance advices for some States show the copayment amount that was withheld for the claim. However, there were remittance advices that did not reflect any copayment amount withheld even though there was a copayment amount that was withheld. It is recommended that the MAO should standardize all remittance advices to reflect the same data elements to ensure consistency in provider notifications. 3. The MAO should implement a process of updating payment amounts to ensure that claims are always paid based on the correct fee schedule amount for any given year.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Because the one claim was only pennies less on the interest amount, the Medicare Advantage Organization (MAO) does not need to adjust this claim to pay the correct interest. However, on the claim where interest was not paid, the MAO should adjust the claim to pay interest. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by December 31, 2007.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The Medicare Advantage Organization (MAO) must revise its policies and procedures to ensure that non-clean claims are processed timely. Conduct training of appropriate staff on the revised Policy and Procedure and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	If Molina makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or a Regional Office-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason. Molina must submit a corrective action plan, describing the actions they will take to assure that they are using the CMS approved NDMC. Provide a timeline when the CMS approved NDMC will be fully adopted.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5823	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Molina must develop policies and procedures (P and P) so that when a member requests a service that requires prior authorization, whether in writing or via the telephone, the provider should be contacted by Molina and directed to submit the pre-authorization request. Molina will also need to document the member and provider requests and track whether or not the provider has followed through on Molina's request. This change in Molina's approach to prior authorizations will also require modification of Molina's provider manual and other provider instructions regarding prior authorizations. Molina should conduct training of appropriate staff on the new P and P. Molina will a lso need to conduct training of its contracted providers in order for them to understand the new process. Molina must submit a corrective action plan (CAP) for this element that includes the new P and P and details of the training it plans to conduct on those P and Ps.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Create and standardize a documented process for all 5 states to ensure all regions are completing initial credentialing and recredentialing, and compiling information in the same manner. Create a checklist for compiling documentation that must be included in the credentialling file and then centralize the documentation for easier access. Rules in the Standard Operating Procedure are very clear of what must be contained in the credentialling file and how information should be obtained. Document the new process in Policy and Procedures to indicate there is a standardized and centralized documentation process for meeting provider credentialing requirements and submit for CMS review.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Create and standardize a process for each state that is similar to the documentation process that is currently being used in Utah to ensure that facilities in all 5 states are being credentialed and monitored unilaterally. Incorporate the new policy and procedure into MA-PRV-01 to ensure continuity and submit for CMS review. Recommend centralized documentation for all 5 states.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	1. All outpatient claims should be paid in accordance with Medicare guidelines. The Part A deductible should only be applied to inpatient claims and should not be applied to outpatient claims. There could be Medicare Advantage Organization (MAO) must develop and implement procedures that will ensure the accuracy of the payment for all outpatient claims as well as the accuracy of any copayment amounts or deductibles that are withheld. 2. Remittance advices for some States show the copayment amount that was withheld for the claim. However, there were remittance advices that did not reflect any copayment amount withheld even though there was a copayment amount that was withheld. It is recommended that the MAO should standardize all remittance advices to reflect the same data elements to ensure consistency in provider notifications. 3. The MAO should implement a process of updating payment amounts to ensure that claims are always paid based on the correct fee schedule amount for any given year.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Molina must ensure that non-contracting providers' clean claims are paid timely. 95% of clean claims are required to be paid within 30 days of receipt. Molina must submit a corrective action plan (CAP) that will ensure that it processes non-participating providers' claims on a timely basis. The plan must include how it will monitor that non-participating provider claims are paid timely. Molina must conduct training of appropriate staff on the payment of 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt. For the CAP to be released, Molina must demonstrate that at least 95% of the non-participating provider claims are paid within 30 days for 2 consecutive quarters. Molina must establish a policy and procedure (P and P) to ensure that claims are logged into the system with an accurate receipt date and that the log date and control date are the same. Molina should conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance. During the review of the sample claims for this element, it became apparent that Molina has inconsistent methods for handling claims processing. One example is that checks to providers are mailed the day after the claim is adjudicated in Utah, yet three days later for another state. Although some differnces are inevitable due to Medicaid differences in each state, it is highly recommended that Molina standardize as many claims processes as possible. Therefore, CMS recommends that as many claim processes as possible be standardized to follow the processes established for the state of Utah.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Because the one claim was only pennies less on the interest amount, the Medicare Advantage Organization (MAO) does not need to adjust this claim to pay the correct interest. However, on the claim where interest was not paid, the MAO should adjust the claim to pay interest. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by December 31, 2007.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The Medicare Advantage Organization (MAO) must revise its policies and procedures to ensure that non-clean claims are processed timely. Conduct training of appropriate staff on the revised Policy and Procedure and submit documentation to the Regional Office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Molina must establish policies and procedures (P and P) to ensure that a denial notice is issued each time a claim is denied. Molina must conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. Molina should conduct an internal audit each month of denied claims. This audit should evaluate whether claims are being properly denied, processed timely, and whether denial notices with proper denial language are being issued. Please submit a summary report once a quarter beginning December 31, 2007, to the Regional Office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	If Molina makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or a Regional Office-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason. Molina must submit a corrective action plan, describing the actions they will take to assure that they are using the CMS approved NDMC. Provide a timeline when the CMS approved NDMC will be fully adopted.	Open
Molina Healthcare, Inc.,	1-562-951-8391	H5926	MA	Audit Findings	9/17/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Molina must develop policies and procedures (P and P) so that when a member requests a service that requires prior authorization, whether in writing or via the telephone, the provider should be contacted by Molina and directed to submit the pre-authorization request. Molina will also need to document the member and provider requests and track whether or not the provider has followed through on Molina's request. This change in Molina's approach to prior authorizations will also require modification of Molina's provider manual and other provider instructions regarding prior authorizations. Molina should conduct training of appropriate staff on the new P and P. Molina will a lso need to conduct training of its contracted providers in order for them to understand the new process. Molina must submit a corrective action plan (CAP) for this element that includes the new P and P and details of the training it plans to conduct on those P and Ps.	Closed
Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Pursuant to 42 CFR 422.204, Freedom Health must ensure that all credentialing and re-credentialing applications are complete and information is current. All items or questions in the application must be addressed with the appropriate response or indicated as not applicable. This requirement also applies to credentialing that is done by delegated entities. In addition, Freedom and its delegated entities must ensure compliance with the requirements mandated by 42 CFR 422.220 regarding physicians and practitioners who opt out of Medicare by reviewing the most recently issued Medicare Opt Out list and include this documentation in each credentialing file.	Closed

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Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Freedom Health must amend its provider contracts to ensure that all contracts include the required contract language, specifically, the accuracy of enrollee records, the right for HHS and its designees to audit extends for a period of 10 years rather than 6 years and complying with and abiding by all federal regulations as mandated by 42 CFR 422.504. The corrective action must include a timeline for amending all deficient provider contracts and submit copies of the amended contracts to the regional office for the cases identified above. Additionally, Freedom must execute a legal and binding contract and/or agreement with the provider identified in case #4 and submit a copy of this document as part of the corrective action plan.	Closed
Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Freedom Health must process grievances according to the timelines mandated by 42 CFR 422.564. Additionally, Freedom Health must correctly distinguish grievances from organization determinations and appeals. In complying with this corrective action, Freedom Health must develop and implement correct policies and conduct training of appropriate staff on these policies and procedures. Freedom Health must also submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.	Closed
Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	1.)Freedom must submit a copy of revised procedures for oversight of USHH. Oversight procedures must ensure that USHH meets CMS requirements for timely processing of clean claims. Oversight procedures should cover training of USHH staff, review of USHH's claims processing system, and review of USHH's policies and procedures. 2.)Freedom must submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 3.)Beginning with October 2007, Freedom must send the regional office a list of all clean unaffiliated provider claims (not line items) paid (not received) during the quarter. The listing should provide the claim number, date of receipt (which may be a date from an earlier quarter), paid date, and number of days it took to process. The report should provide a total of claims paid in 1-30 days, in 31-60 days, and over 60 days. This report is due to the regional office within 15 days of the close of the quarter. Freedom will be required to submit this quarterly report until further notice.	Closed

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Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Freedom Health, Inc. must develop and implement a process for generating EOBs that show the member's financial liability and which allows the MAO to maintain the actual EOB mailed to members. The beneficiary should be able to read the EOB and clearly determine the medical service rendered or items provided to the enrollee that the MAO will not pay for. Furthermore, the beneficiary should be able to determine the extent of his or her financial liability. Additionally, Freedom must submit a list of denial reasons and codes to CMS for review and approval. Freedom must conduct training of claims analysts or specialists on determining the appropriate denial code which will be entered for the claim and denial notice and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The Notice of Denial of Medical Coverage (NDMC) is a standardized written notice to be issued when the MAO denies a MAO enrollee's request for medical service. This is a standard form. MAOs may not deviate from the content of the form and the OMB control number must be displayed on the notice. The NDMC must list the denied medical services or items that were requested by the enrollee or physician. Additionally, the MAO must provide a specific and detailed explanation why the medical services or items are being denied, with the description of any applicable Medicare coverage rule or any other applicable MAO policy upon which the denial decision was based. Freedom must revise their policies and procedures to reflect the requirements outlined in section 40.2.2 of Chapter 13 of the Medicare Managed Care Manual. Freedom must conduct training of appropriate staff on thoroughly completing the Notice of Denial of Medical Coverage as outlined in the Medicare Managed Care Manual, Chapter 13, Section 40.2.2. We highly suggest that the MAO refer to examples of acceptable language in Chapter 13. Freedom must submit documentation which includes the following information: The nature of the training, The date(s) that training occurred, The individuals conducting the training, The names of staff that were trained, and Written training materials used. Last, Freedom must submit a denial reason matrix with clear denial reasons to CMS for review and approval.	Closed

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Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Freedom Health, Inc. must adhere to federal regulations that require MAOs to notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request. If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification. In addition, Freedom must develop and implement policies and procedures to ensure compliance with this requirement. As part of this corrective action, Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.	Closed
Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The Notice of Denial of Medical Coverage (NDMC) is a standardized written notice to be issued when the MAO denies a MAO enrollee's request for medical service. This is a standard form. MAOs may not deviate from the content of the form and the OMB control number must be displayed on the notice. The NDMC must list the denied medical services or items that were requested by the enrollee or physician. Additionally, the MAO must provide a specific and detailed explanation why the medical services or items are being denied, with the description of any applicable Medicare coverage rule or any other applicable MAO policy upon which the denial decision was based. Freedom must revise their policies and procedures to reflect the requirements outlined in section 40.2.2 of Chapter 13 of the Medicare Managed Care Manual. Freedom must conduct training of appropriate staff on thoroughly completing the Notice of Denial of Medical Coverage as outlined in the Medicare Managed Care Manual, Chapter 13, Section 40.2.2. We highly suggest that the MAO refer to examples of acceptable language in Chapter 13. Freedom must submit documentation which includes the following information: The nature of the training, The date(s) that training occurred, The individuals conducting the training, The names of staff that were trained, and Written training materials used. Last, Freedom must submit a denial reason matrix with clear denial reasons to CMS for review and approval.	Closed
Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Freedom Health, Inc. must adhere to federal regulations that require non-contracted providers to submit a completed waiver of liability form in order to appeal a denied claim. In addition, Freedom Health must develop and implement policies and procedures to ensure compliance with this requirement. As part of this corrective action, Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.	Closed

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Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	Freedom Health, Inc. must adhere to federal regulations that require non-contracted providers to submit a completed waiver of liability form in order to appeal a denied claim. Freedom Health must develop and implement correct policies and procedures to ensure compliance with this requirement. As part of this corrective action, Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed. For cases of this nature, CMS is requiring that Freedom Health develop a member letter or notification to inform members that a case is being forwarded to CMS' independent review entity for dismissal and submit this letter to the Regional Office Plan Manager for review.	Closed
Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	Freedom Health, Inc. must adhere to federal regulations that require non-contracted providers to submit a completed waiver of liability form in order to appeal a denied claim. Freedom Health must develop and implement correct policies and procedures to ensure compliance with this requirement. As part of this corrective action, Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed. For cases of this nature, CMS is requiring that Freedom Health develop a member letter or notification to inform members that a case is being forwarded to CMS' independent review entity for dismissal and submit this letter to the Regional Office Plan Manager for review.	Closed
Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	Freedom Health must comply with this requirement by obtaining an appointment of representation form when a request is received from someone other than the enrollee, an assignee or legal representative. As part of this corrective action, Freedom must also develop and implement correct policies and procedures and conduct training of appropriate staff on these policies and procedures. Documentation must be submitted to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.	Closed

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Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	Freedom Health must comply with the fast-track appeals process that is mandated by 42 CFR 422.264. As part of the corrective action, Freedom Health must develop and implement correct policies and procedures to ensure compliance with this requirement. Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.	Closed

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Freedom Health, Inc	1-813-506-6107	H5427	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.	Freedom Health must comply with the fast-track appeals process that is mandated by 42 CFR 422.264. As part of the corrective action, Freedom Health must develop and implement correct policies and procedures to ensure compliance with this requirement. Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.		Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 05 - Quality Assurance	Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).	Recommend that CCHP continue to develop and implement the program protocols and systems, particularly methods and measures for participant monitoring as outlined in Policy QM05, and report on the status of the program as directed by the CMS RO and in conjunction with the monitoring schedule. CCHP should address the following: E1 - There is a process in place to do periodic monitoring of CCIP participants. D1 - The CCIP intervention strategy can be reasonably expected to improve coordination of care and/or health status of participants. D1 - The timing of the initiation/completion of the intervention strategy is designed so that there is at least one ongoing strategy in place. Recommendations are also made regarding the following required and recommended program elements: Required elements - C1 - Criteria for program participation C5 - Process for informing members who are eligible for the CCIP F - Quantitative measures for improvement	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Citizens Choice must establish and maintain effective oversight controls over its delegated entities to ensure that claims are processed according to CMS requirements for timeliness. Citizens Choice must submit a policy and procedure that describes the types of oversight activities it will implement over its delegated entities. Citizens Choice should conduct an internal audit each month of clean claims, both those processed by Citizens Choice as well as all of its contracted medical groups that have claims processing responsibilities for claims. This audit should evaluate whether claims are being processed timely. Please submit a summary report once a quarter to the regional office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Citizens Choice must establish and maintain effective oversight controls over its delegated entities to ensure that claims paid late include the appropriate interest payment. Citizens Choice must submit a policy and procedure that describes the types of oversight activities it will implement over its delegated entities. Citizens Choice should conduct an internal audit each month of clean claims, both those processed by Citizens Choice as well as all of its contracted medical groups that have claims processing responsibilities for claims. This audit should evaluate whether claims are being processed timely. For those that are not, Citizens Choice should ensure that interest has been paid. Please submit a summary report once a quarter to the regional office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	For claims processed both by Citizens Choice and its delegated entities, develop accurate and meaningful descriptions of the denied services so the member understands what services were denied. For claims processed by Citizens Choice, develop a process to ensure that denial notices are sent to members in instances where the member has financial liability for the denied service.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Describe actions CCHP is taking to ensure its delegated entities are meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. The process must include internal and delegation oversight audits to ensure compliance with CMS requirements.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Develop a standard notice to members informing them of a favorable reconsideration decision. Submit via HPMS for review and approval, as well as with the corrective action plan.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	Develop a standard notice to members informing them that you are forwarding their reconsideration request for payment to the IRE for a decision. Submit via HPMS for review and approval, as well as with the corrective action plan.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	Develop a standard notice to members informing them of a favorable reconsideration decision. Submit via HPMS for review and approval, as well as with the corrective action plan.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	Develop a standard notice to members informing them that you are forwarding their reconsideration request for services to the IRE for a decision. Submit via HPMS for review and approval, as well as with the corrective action plan.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	Develop a standard notice to members informing them that you are not processing their reconsideration request on an expedited basis and have transferred it to the standard reconsideration process. Submit via HPMS for review and approval, as well as with the corrective action plan.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	In developing the notice required in RP05, ensure that it explains that you will process the request using the standard timeframe, informs the member of the right to file a grievance if s/he disagrees with the decision not to expedite, informs the member of the right to resubmit a request for an expedited reconsideration with any physician¿s support, and provide instructions about your grievance process and its timeframes.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA	Audit Findings	9/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	Develop a standard notice to members informing them that you are taking an extension on their reconsideration request and that they have the right to file an expedited grievance about this decision. Submit via HPMS for review and approval, as well as with the corrective action plan.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA	Audit Findings	9/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Health Springs must produce: A. Process Procedures 1. Identify cases requiring interdisciplinary assessments and evaluations by trending services potentially requiring guidelines for requesting an extension if justified. 2. Produce policies and guidelines for these services for the Disease Management staff to assist in deciding when these extensions for preservice determinations are necessary. 3. Implement policy and guidelines and audit files to evaluate whether the timeframes for processing meet the regulatory requirement of no later than 14 calendar days after receiving the request or an addtional 14 days if an extesion is jusitied B. Provider Education 1. Identify providers that are not providing clinical assessments timely for decsion making within the regulatory requirements. 2. Establish training to contractors which have not provided information timely for the preservice determination process to meet regulatory guidelines.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA	Audit Findings	9/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	The MAO must ensure that Favorable Standard Pre-service Reconsiderations are processed timely. Training must be provided to staff responsible for processing Pre Service Reconsiderations. Please provide CMS with a copy of the training materials and a list of attendees. Monthly audits of Favorable Standard Pre-Service Reconsiderations must be conducted, and the MAO is required to provide CMS with quarterly updates of its audit results for a six month period.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA	Audit Findings	9/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	The MAO must ensure that Unfavorable Standard Pre-Service Reconsiderations are processed timely. In addition to the implementation of the corrective action plan submitted to CMS on August 10th, 2007, monthly audits of Unfavorable Standard Pre-Service Reconsiderations must be conducted, and the MAO is required to provide CMS with quarterly updates of its audit results for a six month period.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA	Audit Findings	9/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	The MAO must ensure that Unfavorable Standard Pre-Service Reconsiderations are forwarded to the IRE in compliance with 42 CFR 422.618 (b)(1) and C. Training must be provided to staff responsible for processing unfavorable standard pre-service reconsiderations. Please provide CMS with a copy of the training materials and a list of attendees. Monthly audits of unfavorable Standard pre-service reconsiderations must be conducted, and the MAO is required to provide CMS with quarterly updates of its audit results for a six month period.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSpring, Inc.	1-615-236-6116	H0150	MA	Audit Findings	9/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	The MAO must ensure that Requests of Expedited Reconsiderations are processed timely. In addition to the implementation of the corrective action plan submitted to CMS on August 10th, 2007, monthly audits of Requests of Expedited Reconsiderations must be conducted, and the MAO is required to provide CMS with quarterly updates of its audit results for a six month period.	Closed

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Spectrum Health System	1-616-464-8424	H2320	MA-PD	Audit Findings	9/12/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Priority Health must conduct training of appropriate staff on the timely notification and effectuation of notices regarding formulary changes. This should include situations where the Part D sponsor is removing a covered Part D drug from its Part D plan's formulary or making any change in the preferred or tiered cost-sharing status of a covered Part D drug. The Part D plan must either provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective. Or, at the time an affected enrollee requests a refill of the Part D drug, provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed and written notice of the formulary change. Priority Health must submit documentation to the Chicago Regional Office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Priority Health must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Spectrum Health System	1-616-464-8424	H2320	MA-PD	Audit Findings	9/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Priority Health must conduct training of appropriate staff on policies and procedures relating to timely notification of coverage determination and submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Spectrum Health System	1-616-464-8424	H2320	MA-PD	Audit Findings	9/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Priority Health must develop and implement policies and procedures that include a provision stating that the Sponsor must authorize payment and notify the enrollee of its determination no later than 72 hours after receipt of the payment request. If the payment is authorized, the sponsor must make payment within 30 calendar days of the request. Priority Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Spectrum Health System	1-616-464-8424	H2320	MA-PD	Audit Findings	9/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	In the event of an adverse coverage determination, Priority Health must send out written notification of that denial to the enrollee (or enrollees appointed representative, if applicable). The notice must use approved language that is readable and understandable, stating specific reasons for the denial and his or her right to a redetermination. Priority Health must conduct training of appropriate staff on this notification and submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Spectrum Health System	1-616-464-8424	H2320	MA-PD	Audit Findings	9/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Priority Health must revise its policies and procedures for processing requests for exceptions to tiered cost-sharing to include a provision allowing an enrollee or an enrollee¿s appointed representative to file a request for a tiering exception. They also need to include a provision stating that if the Sponsor is waiting on a physician¿s statement to support a tiering exception, they must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing a determination. Priority Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Spectrum Health System	1-616-464-8424	H2320	MA-PD	Audit Findings	9/12/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Priority Health must revise its policies and procedures for processing requests for exceptions for receipt of a non-formulary drug to include a provision allowing an enrollee or an enrollee¿s appointed representative to file a request for a non-formulary exception. They also need to include a provision stating that if the Sponsor is waiting on a physician¿s statement to support a non-formulary exception, they must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing a determination. Priority Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA-PD	Audit Findings	9/10/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	As a result of an internal Audit of their Marketing Representative files, prior to CMS's site visit, the New York State Catholic Health Plan/dba/Fidelis submitted on July 26,2007 during the site visit a Corrective Action Plan detailing the steps that they will take to cure the deficiencies that they had discovered during their review of their files. The deficiences identified by Fidelis were confirmed by the CMS's review of July 26, 2007. CMS reviewed Fidelis's Corrective Action Plan and accepts it as written with the following exclusion: Fidelis must provide CMS with payroll information, regarding the identified personnel in the sample, for licensure and non-licensure to ensure compliance with compensatory commission guidelines. The actions that the New York State Catholic Health Plan will implement to cure the deficiences identified are as follows: As per disclosure requirements for employees of Fidelis Medicare Advantage, Fidelis Care New York will institute a policy which states a licensed marketing representative must disclose to a potential enrollee that he/she may receive compensation for enrolling a prospect into a Fidelis Medicare Advantage Plan. If a marketing representative is meeting with a potential enrollee, in compliance with marketing guidelines, the organization must require that the marketing representative clearly identify the types of products the marketing representative will be discussing, before the marketing representative markets to the potential enrollee. An organization must require that the person performing marketing make the following disclosure, prior to enrollment or at the time of enrollment, in writing, to a potential enrollee: The person that is discussing plan options with you is a licensed employee of Fidelis Medicare Advantage, this person may be compensated based on your enrollment in the plan. Supporting documentation is referenced in the Memorandum of Understanding, located in the Marketing Guidelines Policies and Procedures. The Director of Medicare Marketing will ensure compliance with this procedure and implement it with immediate effect. All Medicare marketing representatives from all three regions, GMRO, NERO and CRO were informed of this procedural change, in a specially convened session on July 27, 2007. Appropriate sign-in sheets and acknowledgements of training will be filed accordingly.	Closed

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The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA-PD	Audit Findings	9/10/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	42CFR 423.120(b)(5)(i-iii) 423.120(b(7) 423.57 (d) The New York State Catholic Health Plan and / or its PBM must submit a policy and procedure to CMS that is consistent. The notice must be provided to the beneficiary at least 60 days prior to the date the formulary change becomes effective. The New York State Catholic Health Plan and /or its PBM should submit through HPMS within 60 days a notice that is consistent with the CMS Marketing Guidelines and with the PDP Guidance - Eligibility, Enrollment and Disenrollment. Please submit the 60 day notice to the attention of Janis R. Remer and Allan Auguste. A sample of this notice is located in Appendix 10 - Model Notice of Formulary or Cost - Sharing Change. The New York State Catholic Health Plan and /or its PBM must submit the title of the person who will monitor this for compliance. Based on the CMS audit performed on July 25, 26 and 27, 2007, CMS found that the New York State Catholic Health Plan is not in compliance with CMS requirements for notice of formulary maintenance changes. The samples audited do not indicate that a consistent and clear notice was used. Instead a variety of unclear notices including EOB's and ANOC's were found in the review folders. It is required that The N.Y. State Catholic Health Plan provide a notice of formulary maintenance changes to be compliant with CMS Marketing Guidelines, CMS requirements or Model 10 from Chapter 18 of the Prescription Drug Benefit Manual. The notice should include the following information: a. The name of the part D drug that is affected. b. Details on whether the covered Part D drug is being removed from the formulary or changing its preferred or tier or cost-sharing status. c. The reason why the covered Part D drug is being removed or changing its preferred or cost sharing status. d. A description of alternative drugs in the same therapeutic class or cost sharing tier, and the anticipated cost sharing for those drugs. e. A description of the means by which the enrollee may obtain an updated coverage determination or an exception to a coverage determination.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Receipt - Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.	Based on an internal audit conducted by the Enrollment department, in conjunction with the Legal Department, and the Director of Medicare, the plan identified applications that were not date stamped in accordance with the department's Policies and Procedures. The Enrollment Department will implement the following plan of correction: Problem: Applications were identified as not being date stamped or not stamped with the correct receipt date. According to the plan, applications taken prior to 11/15/06 and were dated 11/15/06 as marketing activities were not permitted to commence prior to that date. In addition, it was found that one associate was neglecting to date-stamp applications. Resolution: The Director of Enrollment and the departmental management team established an application workflow that will include as one of the steps the date stamping of applications. The new workflow procedures were shared with the associates and staff to ensure that the correct process is followed. As a result of the new procedures, the sales associates were asked to sign acknowledgements confirming their understanding of the correct policies and procedures (see Policies and Procedures ENRMED 2.0 - Reviewing Applications). Sales associates were informed that lack of compliance may result in disciplinary action. The Enrollment Department will conduct a quality assurance sampling on a weekly basis to ensure compliance with this Plan of Correction and the Policy and Procedure.This POC was implemented effective on May 21, 2007. FURTHER ACTIONS REQUIRED-Provide CMS with status on the quality assurance sampling completed to ensure compliance.	Closed

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The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - Based on the review of Enrollment Denials sample, the CMS reviewer found that the MAO failed to correctly notify beneficiaries of denial of enrollment within timeframes specified by CMS in thirteen of fifteen cases. CMS staff received NY State Catholic Health Plan's Plan of Action resulting from an internal audit and found that it addressed this issue and was found acceptable with one further action required. The Enrollment department in conjunction with the Legal Department and the Director of Medicare, found that enrollment and disenrollment letters for enrollees and applicants were not issued on a timely basis. In addition, the content of the letter did not properly display the reason for disenrollment. The enrollment department implemented the following plan of correction: -The enrollment department corrected all of the letters and they are now currently in use. -The director of enrollment and departmental management team implemented workflow procedures with the associate staff to reinforce the process and timeliness in issuing member confirmation letters. -The associates were asked to sign acknowledgements confirming their understanding of the department's policies. They also understand that further oversights may result in disciplinary action. -The enrollment department is expanding the number of associates with training in the Medicare process to provide support if staffing levels are compromised due to extended absences or loss of existing staff. The department has already identified additional resources and has begun training of those resources.* -The enrollment department will conduct a quality assurance sampling on a weekly basis to ensure compliance with this Plan of Correction.* FURTHER ACTIONS REQUIRED-The plan must provide status on the expansion of associates with training in the Medicare process and provide a report with findings based on the review of samples in accordance with the POC. The plan must provide updated Policies and Procedures for CMS review and approval.	Closed
The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Notice Content) - The denial notice meets CMS requirements. If the MA plan is currently enrolled to capacity, the notice explains the procedures that will be followed when vacancies occur.	Based on a review of MAO Enrollment Denials, the reviewer found that enrollment denial notices were not issued. Therefore, the reviewer was unable to determine if the notices met the CMS requirements. Cross-Refer to ER07 for the plan's Plan Of Correction (POC), addressing the denial notices. The POC was implemented effective on May 21, 2007. FURTHER ACTION REQUIRED-Provide CMS with status on the quality assurance sampling completed to ensure compliance with the POC and the Policies and Procedures.	Closed
The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Refer to MR08 for CAR previously shown for this element.	Closed

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The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	CMS staff received (while on site) a Plan of Correction (CAP)from the New York State Catholic Health Plan detailing the steps that it will take to cure the identified deficiencies. CMS reviewed the CAP and partially accepts it with one further action required. The New York State Catholic Health Plan must provide CMS with payroll information for licensed and non licensed Marketing Representatives in order to ensure compliance with N.Y. State Department of Insurance commission guidelines. The CAP is as follows: As per disclosure requirements for employees of the New York State Catholic Health Plan, they will institute a policy which states a licensed marketing representative must disclose to a potential enrollee that he/she may receive compensation for enrolling a prospect into the New York State Catholic Health Plan. If a marketing representative is meeting with a potential enrollee, in compliance with marketing guidelines, the organization must require that the marketing representative clearly identify the types of products the marketing representative will be discussing, before the marketing representative markets to the potential enrollee. An organization must require that the person performing marketing make the following disclosure, prior to enrollment or at the time of enrollment, in writing, to a potential enrollee: The person that is discussing plan options with you is a licensed employee of the New York State Catholic Health Plan and that this person may be compensated based on your enrollment in the plan. Supporting documentation is referenced in the Memorandum of Understanding, located in the Marketing Guidelines Policies and Procedures.	Closed
The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	The New York State Catholic Health Plan must submit a corrective action plan identifying the title of professionals that will be responsible for making decisions resulting in the denial of coverage based upon medical necessity.	Closed
The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	The New York State Catholic Health Plan must submit a policy/procedure for oversight of delegated credentialing/recredentialing activities. The New York State Catholic Health Plan must submit documentation of oversight for the last quarter of 2007 and the first quarter of 2008. Submit the title of the person who will monitor compliance.	Closed
The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	The New York State Catholic Health Plan must submit a policy and procedure for facility credentialing/recredentialing. The New York State Catholic Health Plan must submit a copy of facility credentialing/recredentialing files for the last quarter of 2007 and the first quarter of 2008. Submit title of person who will monitor credentialing/recredentialing process for compliance.	Closed

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The New York State Catholic Health Plan, Inc.	1-718-393-6135	H3328	MA	Audit Findings	9/10/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	An internal audit conducted by NY State Catholic Health Plan, on May 7, 2007, found that grievances and Medicare appeals were not being processed in a manner consistent with Medicare regulations. Therefore, the MA plan developed a Plan Of Correction (Corrective Action Plan) to address the deficiencies found. The MA plan proposes to conduct a monthly meeting in which representatives from the Member Services, and QA Departments along with an independent party to review grievances and appeals to ensure they are correctly categorized and processed. A refresher training between the Quality Oversight Unit and the Medicare Member Services Associates is proposed. The plan also proposes to monitor this area closely on a monthly basis. CMS reviewed the Plan of Correction (CAP) submitted and partially accepts it. NY State Catholic Health Plan must provide the training and submit to the CMS Regional Office, documentation to show that such training took place and the type of information covered. In addition, the Training Manual reviewed, must be revised and submitted to the CMS Regional Office for review and approval.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	CMS requires Plan to conduct internal audit which will capture MAO's grievances for three month period starting October 1, 2007 and ending December 31, 2007. Per CMS requirements, a monthly report must be sent to the Dallas Regional Office for review. A final cumulative report will be due to CMS no later than January 15, 2008.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	CMS requires Plan to conduct internal audit which will capture MAO's grievances for three month period starting October 1, 2007 and ending December 31, 2007. Per CMS requirements, a monthly report must be sent to the Dallas Regional Office for review. A final cumulative report will be due to CMS no later than January 15, 2008.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	CMS requires Plan to conduct internal audit which will capture MAO's grievances for three month period starting October 1, 2007 and ending December 31, 2007. Per CMS requirements, a monthly report must be sent to the Dallas Regional Office for review. A final cumulative report will be due to CMS no later than January 15, 2008.	Closed

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AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	CMS requires Plan to conduct internal audit which will capture MAO's grievances for three month period starting October 1, 2007 and ending December 31, 2007. Per CMS requirements, a monthly report must be sent to the Dallas Regional Office for review. A final cumulative report will be due to CMS no later than January 15, 2008.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Plan must conduct a three month internal audit from October1, 2007-December 31, 2007 of denied OC02 claims. Plan per CMS regulations must submit a monthly report to Dallas Regional Office reflecting findings of audit. Plan must submit a cumulative report to Dallas Regional office and indicate findings in HPMS no later than January 15, 2008	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	When Amerigroup makes a pre-service denial determination, the member must be notified within 14 calendar days from the date the request was received (or 28 days if an extension was taken and justified.) Amerigroup must conduct an internal audit of standard pre-service denials for October 1-December 31, 2007, and submit the results to CMS no later than Jaunary 15, 2008.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Amerigroup and the delegated entity must ensure that the CMS-1003-NDMC with appeals language is provided to the member when a pre-service denial determination is made. The notice must include the denied service and give the correct reason for the denial which is not confusing or misleading to the member. Amerigroup must conduct an internal audit of standard pre-service denials for October 1-December 31, 2007, and submit the results to CMS no later than January 15, 2008.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Plan conducts audit of the favorable claim reconsiderations from October 1, 2007-December 31, 2007. Favorable Claims Reconsiderations must consist of all claims reconsiderations determinations made during the review period that resulted in the MA reversing its decision. Plan per CMS requirements submits monthly report to CMS. P lan submits final cumulative report not later than January 15, 2008.	Closed
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	Plan conducts audit of the unfavorable claim reconsiderations from October 1, 2007-December 31, 2007. Plan per CMS requirements submits monthly report to CMS. P lan submits final cumulative report not later than January 15, 2008.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
AMERIGROUP Corporation	1-203-594-9165	H5817	MA	Audit Findings	9/6/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	Plan conducts audit of the unfavorable claim reconsiderations from October 1, 2007-December 31, 2007. Plan per CMS requirements submits monthly report to CMS. Plan submits final cumulative report not later than January 15, 2008.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Pharmacy Insurance Corporation of America	1-787-625-4343 Ext. 4350	S5775	Part D	Ad-Hoc Compliance Event	9/5/2007	Open	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	PICA has failed to adequately submit complete financial information in a timely manner on several occasions. In a January 9, 2007 letter, CMS noted that PICA submitted its 2006 third quarter financial statements on December 7, 2006, more than three weeks after the November 14, 2006 due date for this documentation. PICA's failure to submit timely complete financial documentation to CMS has continued in 2007. Section XIII of the Medicare Part D Reporting Requirements for Contract Year 2007 (hereinafter referred to as Reporting Requirements), provides clear guidance on the requirements and due dates for financial documents that Part D sponsors are required to submit to CMS. For PICA's annual submission which, as stated in the Reporting Requirements, was due on April 30, 2007, PICA failed to submit the required actuarial opinion as well as the management letter. PICA also failed to submit both the insolvency deposit and the funding for projected losses documentation which were due on May 15, 2007 as part of PICA's quarterly financial documentation. Pursuant to 42 CFR §423.420, PDP sponsors not licensed by a State and for which a waiver application has been approved by CMS must maintain financial solvency and capital adequacy in accordance with the standards established by CMS. As stated in Appendix X of the Medicare Prescription Drug Benefit Solicitation for Applications from Prescription Drug Plans January 21, 2005 (as revised on March 9, 2005), PDP sponsors must show evidence of a minimum net worth of $1.5 million. PICA demonstrated that it met these requirements as part of its initial application to qualify for a 2006 PDP sponsor contract, and must, according to the Medicare Part D Reporting Requirements, provide quarterly financial statements to CMS demonstrating continued compliance with the standard. Since PICA is not currently licensed as a risk bearing entity by any state or territory, CMS is the sole regulatory agency responsible for ensuring that PICA has the financial wherewithal to bear the risk associated with operating a Part D plan. As a result, CMS must continuously assess whether PICA meets all financial requirements under its PDP sponsor contract. Also, because a PDP sponsor's financial solvency has such a direct impact on its ability to provide its enrollees uninterrupted access to their Part D benefits, CMS has a particularly strong obligation to enforce its solvency requirements for unlicensed PDP sponsors. PICA's failure to submit the required financial information in a timely manner impedes CMS' ability to assess whether PICA continues to maintain adequate financial solvency. Consequently, CMS is requesting that PICA submit for CMS approval a CAP detailing the manner in which PICA will ensure that future financial documentation is submitted completely and on time. The CAP should include a discussion of the individuals in the PICA organization responsible for developing and compiling the financial information, the management structure adopted to ensure the accurate and timely production of that information, and the internal timelines adopted to ensure the timely production of all financial information required pursuant PICA's PDP sponsor contract. If PICA fails to submit an adequate CAP, is late in submitting future financial documentation, or submits inadequate financial documentation in the future, CMS may pursue a termination of PICA's PDP sponsor contract pursuant to 42 CFR §423.509 or the imposition of intermediate sanctions (e.g., suspension of marketing and enrollment activities) pursuant to 42 CFR §423.752(b). CMS requests that PICA submit the requested CAP by July 30, 2007.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which includes these provisions and no additional corrective action is required.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	(A) Sierra must revise its policies and procedures to include the requirements discussed above. (B) Sierra must develop and implement a plan to monitor sales staff that includes monitoring of the requirement to provide this written disclosure. (C) Sierra must revise its contracts with marketing representatives to include the missing provisions and provide a plan to monitor this requirement to prevent deficiencies in the future.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which includes these provisions and no additional corrective action is required.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which includes this provision and no additional corrective action is required.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which include these provisions and no additional corrective action is required.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	Sierra must revise its policies and procedures to include the requirements noted in the deficiency above. Sierra submitted revised policies and procedures dated April 2007 which include this provision and no additional corrective action is required.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Sierra must revise its contracts with Long-Term Care Pharmacies to include the missing required language. Also, on contracts with chain pharmacies, Sierra must amend those contracts that do not include a list of pharmacies included in the agreement and include a provision for updating the list.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	(A) Sierra must revise its policies and procedures to include the provisions noticed above. (B) Sierra must revise the template contract and amend the existing contracts to include the provision discussed above. (C) Sierra should provide the results of the audit for CMS review.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Sierra must revise its policies and procedures to include the requirements noted in the deficiency above.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Sierra must revise its policies and procedures to include the missing provisions as follows: 1) the revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include a provision, but 4.1.3.2.5.5 needs to be revised to read: health condition requires but no later than 72 hours, and 2) the revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include this provision and no additional corrective action is required.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	(A) Sierra must revise its policies and procedures to include the requirements discussed above. The revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include this provision and no additional corrective action is required. (B) Sierra must describe the steps it is taking to correct the following as well as plans for monitoring to ensure compliance: begin tracking the date checks are mailed, revise its systems and process to ensure that payment is made when there is a favorable decision, in full or in part, ensure that payment is made within the 30 days allowed, and ensure that decisions are made timely and, if not timely, forwarded to the IRE as required. Once Sierra has made the required revisions to its policy and procedures for this element and all other grievance elements, it must conduct training for all staff involved in the grievance process in any way, from intake of complaints to final adjudication, to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Sierra should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Sierra must revise its policies and procedures to correct the provision discussed in the deficiency above.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Sierra must revise its policies and procedures to include the above noted provisions. The revised policies and procedures dated April 2007 included these requirements and no additional corrective action is required.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	Sierra must revise its policies and procedures to include the above noted provision.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Sierra must revise its policies and procedures to include the above noted provisions.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Sierra must revise its policies and procedures to include the above noted provisions. The revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include these provisions and no additional corrective action is required.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Sierra must revise its policies and procedures to include the above noted provision. For (1) above, the revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include this provision and no additional corrective action is required. However, (2) above must still be corrected.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must develop a revised template and submit it for CMS approval.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must develop a revised template and submit it for CMS approval.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Sierra must revise its policies and procedures to include the above noted provisions. The revised Pharmacy Coverage Requests policy and procedure dated April 2007 does include these provisions and no additional corrective action is required.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Sierra must (A) revise its policies and procedures to include the requirement discussed above, (B) advise CMS how it plans to communicate to members whether their complaints are subject to grievance or coverage determination procedures, (C) develop and submit for approval a notice that is consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug, and (D) Sierra must describe the steps it is taking to categorize cases as appeals, grievances, or both. Also, once Sierra has made required revisions to its policy and procedures for this and all other grievance elements, conduct training for all staff involved in the grievance process in any way, from intake of complaints to final adjudication, to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. S ierra should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Sierra must (A) revise its policies and procedures to include the requirements discussed above and (B) revise its tracking document to include the missing elements discussed above.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	Sierra must revise its policy and procedures to include the requirement discussed above.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Sierra must (A) revise its policies and procedures to include the provisions discussed above, (B) develop a notice consistent with the CMS issued model notice, Notice of Plans Decision to Extend the Deadline for Making a Decision Regarding a Grievance, and (C) Once Sierra has made the required revisions to its policy and procedures for this element and all other grievance elements, it must conduct training for all staff involved in the grievance process in any way, from intake of complaints to final adjudication, to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Sierra should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Sierra must revise its policy and procedures to include the provision discussed above.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	Sierra must revise its policies and procedures to include the requirement discussed above.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Sierra must revise its policies and procedures to include the above noted provisions.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Sierra must revise its policies and procedures to include the above noted provisions.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice template consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice template consistent with CMS-issued model notice, Request for Reconsideration. (C) Sierra must describe the steps it is taking to ensure that enrollees are timely notified of a redetermination, effectuate favorable decisions on a timely basis, and when applicable, notify the enrollee of the status of a case. Once Sierra has made the required revisions to its policy and procedures for this element and all other grievance elements, it must conduct training for all staff involved in the grievance process in any way, from intake of complaints to final adjudication, to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Sierra should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice template consistent with CMS-issued model notice, Request for Reconsideration.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval notice templates consistent with CMS-issued model notice, Notice of Redetermination and Request for Reconsideration.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must develop and implement a system for authorizing and providing a benefit under dispute within 72 hours of receiving the request for redetermination.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Sierra must revise its policies and procedures to include the above noted provisions.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice consistent with the CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice consistent with the CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA-PD	Audit Findings	8/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	(A) Sierra must revise its policies and procedures to include the above noted provisions. (B) Sierra must submit for CMS review and approval a notice consistent with the CMS-issued model notice, Notice of Effectuation to Part D Independent Review Entity.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA	Audit Findings	8/31/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Health Plan of Nevada must ensure that their provider contracts include the new MA language, "agree to audits and inspection by CMS and/or its designees, cooperate, assist, and provide information, as requested, and maintain records a minimum of 10 years." Submit to CMS the corrective action for amending the provider contracts and date certain for its completion. The Regional Office (RO) received your request to consider the acceptance of maintaining medical records in accordance with state and federal requirements without delineating a specific retention time period e.g., ten years via email on July 18, 2007. The request was forwarded to Central Office (CO) on July 19, 2007. To date we have not received a response to your request.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA	Audit Findings	8/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	In accordance with CMS policy and regulations, Health Plan of Nevada/Sierra Health Services must describe the actions it is taking to ensure that notices are sent to members within 30 days, unless an extension is granted. As part of the required corrective action, Health Plan of Nevada/Sierra Health Services must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA	Audit Findings	8/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Refer to the corrective action required for element GV03.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA	Audit Findings	8/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Health Plan of Nevada/Sierra Health Services must send CMS compliant notices (the standardized Notice of Denial of Payment) to members when it denies claims from non-contracted providers. The description of denied services and the denial reasons used with the notice must be clear and understandable. As part of the required corrective action, Health Plan of Nevada/Sierra Health Services must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
UnitedHealth Group, Inc.	1-702-242-7173	H2931	MA	Audit Findings	8/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The health plan identified and corrected this deficiency prior to the CMS audit. A written corrective action (CAP) for standard organization determinations was submitted to the CMS reviewer on 7/17/07. The CAP was reviewed and accepted by CMS on 7/18/07 during the onsite CMS audit. Submit the CAP through HPMS.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	CCHP must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. CCHP must conduct training of appropriate staff on the revised policies and procedures and submit documentation to CMS that details the nature of the training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Revise internal sales rep employment agreements to include a chargeback provision and provide copies of signed revised agreements for all internal sales reps. Revise employment agreements (internal sales reps) and contracts with individually contracted brokers and broker agencies to include a provision prohibiting payments to beneficiaries. Also include a provision stating that any coordinated marketing must be done in accordance with all applicable MA and/or Part D laws, CMS policies, including CMS marketing guidelines, and all Federal health care laws. Provide copies of signed revised agreements/contracts.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	CCHPs policy and procedure #MS-20, dated April 28, 2007, includes the provisions described above. Therefore, no further action is required. CCHP must develop a process to ensure that EOBs clearly indicate the effective date of the formulary change. CCHP must conduct training of appropriate staff on the revised policies and procedures and submit documentation to CMS that details the nature of the training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	CCHP must revise its policies and procedures to include a provision that states that it must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in its service area that requests the contract. CCHP must conduct training of its staff responsible for long-term care network contracting and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	CCHP must revise its policies and procedures to include the provisions described above. CCHP must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	CCHP must submit system reports regarding its transition process utilization for LTC residents to demonstrate that: - it correctly implements the transition process for LTC residents as described in its policies and procedures and that is consistent with its contractual requirements, and - it has and implements a transition process that covers an emergency supply or 'first-fill' of non-formulary Part D drugs.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	CCHPs policy and procedure #UM14, revised May 16, 2007, includes a provision stating that CCHP works with its contracted PBM to ensure that standardized notices are posted at network pharmacies to notify members of their right to request and receive detailed written notices from their plan regarding their drug coverage, including information about the exceptions process. However, this policy and procedure should clearly define the specific notice that is to be posted: `Medicare Prescription Drug Coverage and Your Rights¿. CCHP should also clearly indicate in its policy and procedure that CCHP conducts oversight of its contracted PBM to ensure that they are conducting ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. CCHP must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CCHP must also revise the template contracts between their contracted PBM and each of their network pharmacies to include a provision requiring pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception. Lastly, CCHP must provide CMS with a notice consistent with CMS-issued model notice, Medicare Prescription Drug Coverage and Your Rights. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	CCHPs policy and procedure #MS-23, dated May 1, 2007, includes provisions for tracking and addressing all requests for redeterminations. Therefore, no further action is required. CCHP must submit documentation to CMS to demonstrate that its system to track and address in a timely manner enrollees oral and written requests for exceptions, coverage determinations, and redeterminations tracks: - Date of disposition - Date of notification	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CCHP must develop a process to ensure that the date and time the member is notified of standard coverage determinations is documented, such as the use of screen prints of call notes/phone logs showing the date and time the member was notified. CCHP must ensure that all denial notices contain the OMB control number. CCHP must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CCHP must provide CMS with a notice consistent with CMS-issued model notice, Notice of Case Status. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	CCHP must notify enrollees of standard coverage determinations concerning payments as well as make payments timely and provide documentation of this to CMS. CCHPs policy and procedure #UM 14, revised May 16, 2007, contains the provisions described above. Therefore, no further action is required.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	CCHPs policy and procedure #UM 14, revised May 16, 2007, contains the above provision. Therefore, no further action is required. CCHP has provided CMS with a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance. CCHPs notice entitled 'Pharmacy Service Requested Do Not Meet Expedited Criteria' was approved in HPMS on August 8, 2007. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CCHP must develop a process to ensure that the date and time the member is notified of standard coverage determinations is documented, such as the use of screen prints of call notes/phone logs showing the date and time the member was notified. CCHP must ensure that all denial notices contain the OMB control number. CCHP must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CCHPs policy and procedure #MS-23, dated May 1, 2007, contains a provision stating that CCHP must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Therefore, no further action is required. CCHP must provide CMS with a notice consistent with CMS-issued model notice, Notice of Case Status. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	CCHP must revise its policies and procedures to include a provision stating that if the decision on an expedited coverage determination is adverse, CCHP must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. CCHP must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CCHPs policy and procedure #UM14, revised May 16, 2007 contains the remainder of the provisions described above. Therefore, no further action is required.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	CCHPs policy and procedure #UM14, revised May 16, 2007, and Pharmacy/Part D Timeliness Standards ¿ Exceptions Requests Document, include the provisions described above. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	CCHPs policy and procedure #UM14, revised May 16, 2007 and Pharmacy/Part D Timeliness Standards - Exceptions Requests Document, include the provisions described above. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	CCHPs policy and procedure #UM14, revised May 16, 2007 contains the provisions described above. Therefore, no further action is required.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	CCHP has demonstrated that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. CCHP submitted grievance acknowledgement letters on HPMS that inform enrollees whether their complaint is subject to grievance or coverage determination procedures. These letters were approved in HPMS on August 29, 2007. Therefore, no further action is required. CCHP has provided CMS with a notice consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug. This notice was approved in HPMS on August 28, 2007. Therefore, no further action is required. CCHP must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains an incorrectly categorized sample. Based on the analysis, CCHP is to provide to CMS a corrective action plan to ensure that cases will be correctly categorized.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	CCHP must revise its grievance policies and procedures to include a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary. CCHP must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CCHP must also submit documentation to CMS to demonstrate that its system for logging or capturing enrollees grievances tracks: - Date of disposition of grievance - Date the enrollee was notified of disposition	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	CCHPs Appeals and Grievances Training policy and procedure dated April 29, 2007 demonstrates that the Plan has and implements training on grievance policies and procedures. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	CCHP must revise its policies and procedures to include a provision stating that the enrollee must immediately be notified in writing when CCHP extends the deadline. CCHPs policy and procedure #MS-21A entitled 'Standard Grievances' includes a provision stating that 'CCHP may take up to an additional fourteen (14) days if the member requests it or the delay would be in the best interests of the member.' However, CCHP should revise the verbiage for this provision to state specifically that 'the 30 day timeframe may be extended by 14 days or less if the enrollee requests the extension or if the Part D sponsor justifies a need for additional information and documents how the delay is in the best interest of the enrollee.' CCHP must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CCHP has provided CMS with a notice consistent with CMS-issued model notice for ¿Notice of Plan¿s Decision to Extend the Deadline for Making a Decision Regarding a Grievance.¿ This notice was approved in HPMS on August 1, 2007. Therefore, no further action is required	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	CCHP has provided CMS with a notice consistent with CMS-issued model notice, Notice of Plans Decision Regarding a Grievance, which includes instructions to describe the enrollees right to file a written complaint with the QIO for grievances related to quality of care. This notice was approved in HPMS on August 8, 2007. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	CCHPs policy and procedure #MS-21B, dated April 29, 2007, includes the above provision. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	CCHPs policy and procedure #UM14, revised May 16, 2007, includes the provisions described above. Therefore, no further action is required	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	CCHP must revise its policies and procedures to include the following provisions: - a provision for maintaining an efficient and convenient means for an enrollee or prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and - a provision for maintaining documentation of expedited redetermination requests in a case file. CCHP must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. CCHPs policy and procedure #MS-23, dated May 1, 2007 includes the remainder of the provisions described above. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	CCHPs policy and procedure #MS-23, dated May 1, 2007, includes the provisions described above. Therefore, no further action is required.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	CCHPs policy and procedure #MS-23, dated May 1, 2007, includes the provisions described above. Therefore, no further action is required. CCHP has provided CMS with a notice consistent with CMS-issued model notice, Notice of Right to Expedited Grievance. This notice was submitted in HPMS under File and Use on August 3, 2007. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CCHPs policy and procedure #MS-23, dated May 1, 2007, includes the provisions described above. Therefore, no further action is required. CCHP must provide CMS with a notice consistent with CMS-issued model notice, Notice of Redetermination. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP). CCHP must also provide CMS with a notice consistent with CMS-issued model notice, Request for Reconsideration. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CCHP must revise its policies and procedures to include a provision stating that for redeterminations favorable to the enrollee, the Part D sponsor must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. CCHP must conduct training of appropriate staff on these policies and procedures and this system and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Policy and procedure #MS-23, dated May 1, 2007, includes the remainder of the provisions described above. Therefore, no further action is required. CCHP must provide CMS with a notice consistent with CMS-issued model notice, Notice of Redetermination. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP). CCHP must also provide CMS with a notice consistent with CMS-issued model notice, Request for Reconsideration. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CCHP must revise its policies and procedures to include a provision stating that notification of a favorable decision may be made orally or in writing. CCHP must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. CCHPs policy and procedure #MS-23, dated May 1, 2007, includes the remainder of the provisions described above. Therefore, no further action is required. CCHP must provide CMS with a notice consistent with CMS-issued model notice, Notice of Redetermination. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP). CCHP must also provide CMS with a notice consistent with CMS-issued model notice, Request for Reconsideration. This notice should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	CCHPs policy and procedure #MS-23, dated May 1, 2007 includes the provision described above. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	CCHPs policy and procedure #MS-23, dated May 1, 2007, includes the provisions described above. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	CCHPs policy and procedure #MS-23, dated May 1, 2007, includes the provisions described above. Therefore, no further action is required.	Closed

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Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	CCHPs policy and procedure #MS-23, dated May 1, 2007, includes the provisions described above. Therefore, no further action is required.	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	CCHPs policy and procedure #MS-23, dated May 1, 2007 includes the provisions described above. Therefore, no further action is required	Closed
Honored Citizens Choice Health Plan	1-562-207-4518	H3815	MA-PD	Audit Findings	8/30/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	CCHPs policy and procedure #MS-23, dated May 1, 2007 includes the provisions described above. Therefore, no further action is required.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	The Part D Sponsor must develop and implement written policies and procedures for providing notification of negative formulary changes to authorized prescribers, network pharmacies, and pharmacists. The following must be included: 1 - a provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes at least 60 days prior to the date the change becomes effective, 2 - a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market, 3 - a description of the method(s) used to provide notification of formulary changes. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	The Part D Sponsor must update its written policies and procedures in accordance with the CMS Medicare Marketing Guidelines to include: 1 - a provision to conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all CMS policies, 2 - a requirement that any person directly employed or contracted to market on behalf of the Part D Sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The corrective action plan needs to include how the persons who conduct marketing will be monitored in this area. The Part D Sponsor must review direct and downstream contracts with all persons marketing on its behalf. If the contracts do not include the following provisions, they must be amended to include the following as shown in Section 11 of the CMS Medicare Marketing Guidelines: 1 - a provision to provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. 2 - a provision stating that any coordinated marketing to be carried out by the persons must be done in accordance with all applicable Medicare Advantage and Part D laws, CMS policies, including CMS marketing guidelines, and all Federal health care laws (including civil monetary penalty laws). The corrective action plan needs to include a timeline for reviewing and amending the contracts.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	The Part D Sponsor must develop and implement written policies and procedures regarding beneficiary notification of formulary changes. The following items must be included: 1 - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change, 2 - a provision to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these notification requirements, including ongoing monitoring for compliance. The Part D Sponsor reported no formulary changes occurred during the six month period audited by CMS. Therefore, there were no cases to be reviewed for compliance with the Federal regulations. Please send a monthly report identifying the Universe for WS-MR4_D, Provision of Notices Regarding Formulary Changes (Part D). Cases listed in the universe will be subject to a CMS audit.	Closed

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PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	The Part D Sponsor must develop and implement written policies and procedures for providing notification of formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage. The following must be included: 1 - a provision with a description of the procedures for providing a notice of maintenance formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, 2 - a provision with a description of the procedures for providing a notice of other formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, 3 - a provision with a description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, 4 - a description of the method(s) used to provide notification of formulary changes. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Part D Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	The Part D Sponsor must develop and implement written policies and procedures regarding the transition process for residents of long-term care (LTC) facilities to include: 1 - requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, 2 - a provision to abide by extensions to the transition period in accordance with CMS policy. The Sponsor must update its policies and procedures Pharm PA-04 Long Term Care Pharmacy Access Section V, Bullet C. Also, the auditor noted Section III is missing from this document (sections jump from II to IV). The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The corrective action plan must describe the steps being taken to ensure compliance with this transition process. The Part D Sponsor must program its system to allow reports regarding the Part D sponsor's transition process utilization for LTC residents to be printed and submitted to the auditors. This is to show the auditors that the Sponsor correctly implements the transition process for LTC residents as described in its Standard Operating Procedures and consistent with its contractual requirements, and that the sponsor has and implements a transition process that covers an emergency supply or first-fill of non-formulary Part D drugs. The corrective action plan needs to include a systems report for the most recently closed month.	Closed

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PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	The Part D Sponsor must develop and implement written policies and procedures regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requsting an exception that includes: 1 - a provision for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist, 2 - a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices. Or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The corrective action plan needs to include how the Sponsor will conduct ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. The "Medicare Prescription Drug Coverage and Your Rights" pharmacy notice needs to be submitted for CMS review and approval to the CAP reviewer through HPMS.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	The Part D Sponsor must conduct training of appropriate staff on the correct procedures to follow in notifying the beneficiary of a favorable coverage determination and how to properly document the case file. Submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The corrective action plan must include a detailed description of the steps the Sponsor is taking to ensure compliance with the notification requirements and to ensure that each case file is properly documented.	Closed

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PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	The Part D Sponsor must revise its policies and procedures to include: 1 - a provision stating that the Sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, 2 - provisions stating that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D Sponsor to forward the enrollee's request to the Independent Review Entity within 24 hours of the expiration of the adjudication timeframe. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	The Part D Sponsor needs to update its policies and procedures to: 1 - include the name of an office and/or department that is designated to receive both oral and written requests for expedited coverage determinations. Include a telephone number for the oral requests. May include a facsimile number to facilitate receipt of these requests, 2 - state that all oral requests must be documented in writing and that documentation of the request must be maintained in the case file. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these requirements.	Closed

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PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	The Part D Sponsor must revise its policies and procedures to include a provision stating that it must inform the enrollee within 24 hours when the case is forwarded to the IRE. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	The Part D Sponsor must revise its policies and procedures to include a provision stating that if oral notice is provided for an adverse decision, the notice must satisfy the following requirements: 1 - state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, 2 - provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, 3 - provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed

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PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	The Part D Sponsor must revise its policies and procedures to include: 1 - a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, it must do so immediately, 2 - a provision stating that if the Sponsor makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, 3 - a provision stating that if the Sponsor is waiting on a physician's statement in support of a tiering exception request, the Sponsor must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the tiering exception. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	The Part D Sponsor must revise its policies and procedures to include: 1 - a provision stating that if the Sponsor makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, 2 - a provision stating that the Sponsor must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, 3 - a provision stating that if the Sponsor is waiting on a physician's statement in support of a formulary exception request, the Sponsor must wait a minimum of 96 hours after receiving a standard request or a minimum of 48 hours after receiving an expedited request before issuing its determination on the formulary exception, 4 - that the Sponsor does not restrict the number of exception requests submitted per enrollee. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Part D Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed

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PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	The Part D Sponsor must revise its policies and procedures to include a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Note that Part D Sponsors may not create a tier specifically designed for approved non-formulary exceptions, and they may not assign approved non-formulary drugs to a high-cost specialty tier if the cost-sharing level that applies to the high-cost tier exceeds 25% of the actual costs of the drugs contained in that tier. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	The Part D Sponsor has policies and procedures that includes definitions of inquiries, grievances and coverage determinations and how to categorize them. However, the staff is not following the policies and procedures. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these requirements.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	The Part D Sponsor has policies and procedures that includes definitions of inquiries, grievances and coverage determinations and how to categorize them. However, the staff is not following the policies and procedures. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions. After the training is provided, the Sponsor needs to provide, on a monthly basis, a universe of its grievances. This needs to be provided to CMS electronically for Worksheet GV1_D: Standard Grievances (Part D) as it was for the audit. CMS will select samples to review.	Closed

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PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	The Part D Sponsor has policies and procedures that includes definitions of inquiries, grievances and coverage determinations and how to categorize them. However, the staff is not following the policies and procedures. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions. After the training is provided, the Sponsor needs to provide, on a monthly basis, a universe of its grievances. This needs to be provided to CMS electronically for Worksheet GV1_D: Standard Grievances (Part D) as it was for the audit. CMS will select samples to review.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	The Part D Sponsor must develop the Notice of Plan's Decision Regarding a Grievance, based on the CMS-issued model notice, submit it to the CAP reviewer at CMS through HPMS and begin using it when it is approved by CMS. Proper use of this notice needs to be included in the policies and procedures. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	The Part D Sponsor needs to revise the marketing material ID number H4527 1009 5015 ReqRecon CMS and submit to the CAP reviewer via HPMS to correct the following: Delete the sentence at the top as it is instructions to the sponsor. It reads "Part D Plans must include this Request for Reconsideration form with each adverse Redetermination Notice and must complete the following Plan identifying information:" Reminder: the material ID number needs to be formatted following the Medicare Marketing Guidelines. Also include "CMS Approval Date XX/XXXX". The Part D Sponsor's logo is to be on the notices, not the PBM's logo, even if the sponsor delegated to the PBM to send the notices. The Sponsor must conduct training of appropriate staff to ensure they will recognize incomplete notices and file documentation. The Sponsor needs to submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance in these areas.	Closed

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PSO Health Services, LLC	1-210-949-4153	H4527	MA-PD	Audit Findings	8/28/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	The Part D Sponsor must develop policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner to include: 1 - a provision stating that case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file, 2 - a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. The Sponsor must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. The Sponsor must describe the steps it is taking to ensure compliance with these provisions.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Development of policies and procedures for testing all individuals involved with selling Medicare Assured products. Corrective action will also include the development and administration of knowledge assessment tests to staff.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Development of policies and procedures for testing all individuals involved with selling Medicare Assured products. Corrective action will also include the development and administration of knowledge assessment tests to staff.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Notifications to delegate UPMC Physician Services to consistently document verfication of quality of care issues and Medicare Opt-out. Instructions to update Physician Practitioner File checklist to include this information. Continued monitoring and auditing to determine compliance. Update of any policies and procedures as necessary.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Modification of contract templates and notification to all affected providers of the updated record maintenance requirements. Update of all affected policies and procedures as necessary.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Gateway has submitted a template letter for notifying members or their authorized representative of the extension to the grievance. Gateway will also update all policies and procedures related to this change as necessary and submit to CMS.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Gateway has submitted a template letter for notifying members or their authorized representative of the extension to the grievance. Gateway will also update all policies and procedures related to this change as necessary and submit to CMS.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Gateway is currently working with vendor to provide a descriptive denial message on EOBs with final implementation set for October 1, 2007. Gateway will update any policies and procedures as necessary and submit to CMS.	Closed

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Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Gateway will develop a process for verbal notification to the member as well as submit a template for a written favorable expedited decision. Training will be provided to the appropriate staff, and policies and procedures will be updated as necessary.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Gateway will develop a process for verbal notification to the member as well as submit a template for a written favorable expedited decision. Training will be provided to the appropriate staff, and policies and procedures will be updated as necessary.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	Gateway implementation of a process by which appropriate and complete documentation of the DENC and delivery to the member is ensured. Updated policies and procedures for any affected areas as necessary.	Closed
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	Gateway implementation of a process by which appropriate and complete documentation of the DENC and delivery to the member is ensured. Updated policies and procedures for any affected areas as necessary.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Gateway Health Plan	1-412-255-4296	H5932	MA	Audit Findings	8/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	Gateway will submit a template letter and update any policies and procedures as necessary to meet this requirement.	Closed
Health Care Service Corporation	1-972-766-1645	H3208	MA-PD	Audit Findings	8/24/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Part D sponsor must adhere to its 01/01/2006 Standard Operating Procedures ¿2.2.3 MedD Approval Process for Coverage Determination and Redetermination Requests¿ which clearly indicates that enrollees are to be provided with verbal and/or written notification. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Health Care Service Corporation	1-972-766-1645	H3208	MA-PD	Audit Findings	8/24/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Part D sponsor must adhere to its 10/01/2005 Standard Operating Procedures ¿13-GV01 Complaint Categorization (¿Grievances vs. Coverage Determinations¿)¿ which clearly indicates that enrollees are to be informed whether complaints are subject to its grievance procedures or coverage determination procedures. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed

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Health Care Service Corporation	1-972-766-1645	H3208	MA-PD	Audit Findings	8/24/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Part D sponsor must adhere to its 01/01/2006 Standard Operating Procedures ¿13-GV04 Timely Notification of Grievance Disposition¿ which clearly indicates that enrollees are to be provided with timely verbal and/or written notification. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Health Care Service Corporation	1-972-766-1645	H3208	MA-PD	Audit Findings	8/24/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Part D sponsor must adhere to its 01/01/2006 Standard Operating Procedures ¿13-GV04 Timely Notification of Grievance Disposition¿ which clearly indicates that enrollees are to be provided with verbal and/or written notification once a determination has been made. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Health Care Service Corporation	1-972-766-1645	H4531	MA-PD	Audit Findings	8/24/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Part D sponsor must adhere to its 01/01/2006 Standard Operating Procedures ¿2.2.3 MedD Approval Process for Coverage Determination and Redetermination Requests¿ which clearly indicates that enrollees are to be provided with verbal and/or written notification. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Health Care Service Corporation	1-972-766-1645	H4531	MA-PD	Audit Findings	8/24/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Part D sponsor must adhere to its 10/01/2005 Standard Operating Procedures ¿13-GV01 Complaint Categorization (¿Grievances vs. Coverage Determinations¿)¿ which clearly indicates that enrollees are to be informed whether complaints are subject to its grievance procedures or coverage determination procedures. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed

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Health Care Service Corporation	1-972-766-1645	H4531	MA-PD	Audit Findings	8/24/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Part D sponsor must adhere to its 01/01/2006 Standard Operating Procedures ¿13-GV04 Timely Notification of Grievance Disposition¿ which clearly indicates that enrollees are to be provided with timely verbal and/or written notification. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Health Care Service Corporation	1-972-766-1645	H4531	MA-PD	Audit Findings	8/24/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Part D sponsor must adhere to its 01/01/2006 Standard Operating Procedures ¿13-GV04 Timely Notification of Grievance Disposition¿ which clearly indicates that enrollees are to be provided with verbal and/or written notification once a determination has been made. Part D sponsor must train staff on Manual Chapter 18 and Standard Operating Procedures. Part D sponsor must provide RO with evidence of such training.	Closed
Health Care Service Corporation	1-972-766-1645	H3208	MA	Audit Findings	8/16/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	HISC must revise Policy # M-103-0320, Credentialing and Recredentialing Policy, to specify the Office of the Inspector General (OIG) website at www.oig.hhs.gov/fraud/exlusions/listofexcluded.html (Chptr 6, Sec 60.2) as the appropriate agency to verify Medicare excluded providers and entities. HISC must establish a mechanism for ongoing monitoring of Medicare opt out verification to ensure continued internal compliance. Policies and procedures should be updated to reflect these improvements. HISC must revise its oversight of its delegated entities to ensure that the most recent Medicare opt out list is reviewed at the points of initial credentialing and recredentialing. Policies and procedures should be updated to reflect these improvements. HISC must provide the regional office with the revised policies, procedures and mechanism(s) planned for continued internal and delegated entity compliance to the Medicare opt out credentialing requirement. In addition, HISC should conduct an internal audit of all delegated entities, on a monthly basis, to determine ongoing compliance. Your plan for corrective action should, at a minimum, provide for the submission of a quarterly summary report to the Regional Office of the monthly audit findings. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. HISC must continue to provide a quarterly update of internal audit results until CMS determines that HISC meets regulatory requirements.	Closed

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Health Care Service Corporation	1-972-766-1645	H3208	MA	Audit Findings	8/16/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	HISC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.568(e). HISC must take appropriate steps to correct denial notices for noncontracting provider claims to ensure that notices provide a description of the actual service as well as a specific denial reason. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. HISC must also provide the format and content of revised policies and procedures for our approval and the CAP should include a provision for ongoing monitoring of this delegated function. Following corrective actions taken, HISC should conduct an internal audit, on a monthly basis, of claim denials issued by the organization to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a quarterly summary report to the Regional Office of the monthly audit findings. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. HISC must continue to provide a quarterly update of internal audit results until CMS determines that HISC meets regulatory requirements	Closed
Health Care Service Corporation	1-972-766-1645	H3208	MA	Audit Findings	8/16/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	The CAPs for elements OP10 and OP11 partially satisfy this request. In addition, HISC must capture, on a monthly basis, timeliness information for all notices (Detailed Explanation of Non-Coverage CMS 10095-B) issued by the organization at the request of the QIO. This information should be included in the organization's summary quarterly report to the Regional Office. Further, HISC must ensure that its policies and procedures accurately capture the necessary actions required to furnish the CMS -10095-B on a timely basis following notification by the QIO.	Closed
Health Care Service Corporation	1-972-766-1645	H3208	MA	Audit Findings	8/16/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	The CAPs for elements OP10 and OP11 partially satisfy this request. In addition, HISC must capture, on a monthly basis, notice content information for all notices (Detailed Explanation of Non-Coverage of provider services CMS-10095-B) issued by the organization at the request of the QIO. This information should be included in the summary quarterly report to the Regional Office. Further, HISC must ensure that its policies and procedures accurately capture the actions necessary to furnish all required notice content elements of the CMS -10095-B.	Closed
Health Care Service Corporation	1-972-766-1645	H4531	MA	Audit Findings	8/16/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	HISC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.568(e). HISC must take appropriate steps to correct denial notices for noncontracting provider claims to ensure that notices provide a description of the actual service as well as a specific denial reason. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. HISC must also provide the format and content of revised policies and procedures for our approval and the CAP should include a provision for ongoing monitoring of this delegated function. Following corrective actions taken, HISC should conduct an internal audit, on a monthly basis, of claim denials issued by the organization to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a quarterly summary report to the Regional Office of the monthly audit findings. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. HISC must continue to provide a quarterly update of internal audit results until CMS determines that HISC meets regulatory requirements	Closed

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Health Care Service Corporation	1-972-766-1645	H4531	MA	Audit Findings	8/16/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	The CAPs for elements OP10 and OP11 partially satisfy this request. In addition, HISC must capture, on a monthly basis, timeliness information for all Detailed Explanation of Non-Coverage (CMS 10095-B) notices issued by the organization at the request of the QIO. This information should be included in the organization's summary quarterly report to the Regional Office. Further, HISC must ensure that its policies and procedures accurately capture the necessary actions required to furnish the CMS -10095-B on a timely basis following notification by the QIO.	Closed
Health Care Service Corporation	1-972-766-1645	H4531	MA	Audit Findings	8/16/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	The CAPs for elements OP10 and OP11 partially satisfy this request. In addition, HISC must capture, on a monthly basis, notice content information for all notices (Detailed Explanation of Non-Coverage of provider services CMS-10095-B) issued by the organization at the request of the QIO. This information should be included in the summary quarterly report to the Regional Office. Further, HISC must ensure that its policies and procedures accurately capture the actions necessary to furnish all required notice content elements of the CMS -10095-B.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA	Audit Findings	8/9/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Wellcare must improve the rapid disenrollment rate tracking process and develop a policy and procedure describing how this information is collected, tracked and monitored. Wellcare must set a standard for an unacceptable disenrollment rate and develop a process on how agents will be disciplined when their rapid disenrollment rates reach an unsatisfactory level. Wellcare must provide CMS with: 1. An overview of the rapid disenrollment rate tracking process 2. Policy and procedure for collecting, tracking and monitoring rapid disenrollment rate data 3. Rapid disenrollment rate standard 4. Agent disciplinary action procedure pertaining to unsatisfactory rapid disenrollment rates	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA	Audit Findings	8/9/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Wellcare must provide a policy and procedure on the oversight and management controls they have over all agents who sell MAO plans, including marketing representatives, agents and brokers. The procedure must include how Wellcare collects, monitors and stores documentation and how appropriate disciplinary actions are administered. Wellcare must develop a policy and procedure describing how rapid disenrollment rate information is collected, tracked and monitored. Wellcare must set a standard for an unacceptable disenrollment rate and develop a process for discipling agents with unacceptable rapid disenrollment rates. Wellcare must expand their Marketing / Sales training to include more comprehensive product and benefit specific information specific to Wellcare. Additionally, Wellcare must include product and benefit specific information on the agent tests to ensure that they are very familiar with the Wellcare products and benefits and are able to address all beneficiary questions.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA	Audit Findings	8/9/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Wellcare must revise its provider agreements to include language that will ensure that the element, CN04 - Abides by Federal Requirements provision, be included in all contracts and/or amendments accordingly. Wellcare must revise its policies and procedures to ensure that element CN04 is in compliance. Wellcare must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including but not limited to: the materials used in the training, the individuals conducting the training, and the individuals being trained. WellCare must also provide a quarterly status report to CMS for the next 6 months as to the progress of this matter. Status report should include, but not limited to, the process in which the MAO intends to implement the amended language into the current provider contracts, timeline for said project, completion dates, responsible staff for each of the tasks that will be included during this process. Provider Contract Templates should be submitted for all types of MAO contracts (i.e., Direct and Downstream, etc.).	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA	Audit Findings	8/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MA organization must conduct appropriate staff training to ensure that denial notices are sent to member when a claim is denied either partially or in full. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct quarterly self audits and provide CMS with the results of the audit for a period not to exceed six months.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA	Audit Findings	8/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	The MA organization must conduct appropriate staff training to ensure that denial notices are sent to the member when a standard Service is denied. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct monthly self audits for one quarter and then quarterly thereafter for one year. Please provide CMS with the results of these audits 30 days after completion.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA	Audit Findings	8/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MA organization must conduct appropriate staff training to ensure that denial notices are sent to the member when a standard Service is denied. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct monthly self audits for one quarter and then quarterly thereafter for one year. Please provide CMS with the results of these audits 30 days after completion.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA	Audit Findings	8/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MA organization must conduct appropriate staff training to ensure that denial notices are sent to members when an expedited decision is rendered. Provide CMS with copies of the training material in addition to attendance rosters reflecting the date and subject matter of the training for the staff involved. Additionally, the MA organization must conduct monthly self audits for one quarter and then quarterly thereafter for one year. Please provide CMS with the results of these audits 30 days after completion.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1032	MA	Audit Findings	8/9/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MAO must ensure that favorable reconsiderations are processed timely. Although policy number C7AG-013 (Medicare Non-QIO Review/Non Part Dprescription Appeals Procedure) addresses the timeliness of processing reconsiderations, 40% of the samples reviewed did not meet the 60 day requirement. Training must be provided to staff responsible for processing appeals. Please provide CMS with a copy of the training materials and a list of attendees. Monthly audits of favorable claims reconsiderations must be conducted, and the MAO is required to provide CMS with quarterly updates of its audit results for a six month period.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	S4802	Part D	Ad-Hoc Compliance Event	8/8/2007	Closed	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	Basis for Requesting Corrective Action Plan During 2006 and 2007, CMS has routinely calculated measures of Part D sponsors' performance in several operational areas. In some areas where CMS has established minimum performance standards, Sterling has a demonstrated pattern of failure to meet those standards. In other areas, CMS has identified sponsors whose performance represents an outlier relative to all other sponsors. Sterling is an outlier in three of these performance measures. CMS had also previously identified some of these issues during its August 2006 audit of Sterling¿s readiness to provide services to automatically assigned low-income subsidy (LIS) eligible beneficiaries. In a letter dated September 25, 2006, CMS informed Sterling that it had determined that it was not prepared to perform the tasks critical to ensure the effective transition of LIS beneficiaries to Sterling¿s plans during the fall of 2006, with an enrollment effective date of January 1, 2007. In the same letter, CMS informed Sterling that it could receive automatic enrollments of individuals who became LIS-eligible Medicare beneficiaries during 2007 if it requested and passed a second readiness audit. To date, Sterling has not requested such an audit and its plans remain closed to automatic enrollment of US beneficiaries. 4rx Since January 2007, Sterling has failed to meet the required standard for multiple months. This finding is consistent with the August 2006 audit which indicated that Sterling did not have adequate processes or systems to meet the 4Rx requirements. US Beneficiary Match Rate As of April 2007, Sterling failed to meet the required standard. This finding is consistent with the August 2006 audit results which indicated that the Sterling did not have the processes and systems in place to meet the LIS data processing requirements. Rate of Timely Processing ofBeneficiarv Requests for Exceptions and Appeals Part D sponsors are required to make decisions on beneficiary requests for exceptions and appeals within the timeframes stated in 42 CFR §423, Subpart M. When sponsors fail to issue determinations within the established timeframes, the failure constitutes an adverse determination, and the sponsors must forward the matter to the independent review entity (IRE) within 24 hours. CMS' most recent analysis indicates that Sterling's exceptions and appeals were auto-referred to the IRE for failure to make timely decisions at a rate of 14.4 per 10,000 enrollees. This rate placed Sterling as an outlier among other PDP sponsors, as Sterling¿s rate was among the worst, 5 percent. Request for Corrective Action Plan CMS issues this contract renewal qualification notice based on the information it has available as of the date of this notice and the evaluation standard it must apply to that information to make the determination pursuant to 42 CFR §423.507(b)(2). However, CMS notes that Sterling is currently out of compliance with several Part D requirements. Therefore, CMS is requesting that Sterling take corrective action on the issues described below.	Closed

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UnitedHealth Group, Inc.	1-702-242-7173	S5917	Part D	Ad-Hoc Compliance Event	8/8/2007	Closed	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	1. Involuntary disenroilment of beneficiaries who paid monthly premiums timely. In mid-February 2007, CMS began receiving reports that certain beneficiaries had been notified that they would be involuntarily disenrolled from the SierraRx Plus plan for failure to pay February premiums, due on February 1, 2007. Many of these beneficiaries had received the notice when they had in fact paid their February premiums on time and had their cancelled checks as documentation. These reports came from individual beneficiaries, state agencies, and advocacy organizations. When CMS verbally directed Sierra on February 27, 2007 to reinstate these beneficiaries into the SierraRx Plus plan, Sierra refused. 2. Involuntary disenroliment of beneficiaries with HIV/AIDS Individuals with HIV generally depend on several brand name medications to pursue effectively their courses of treatment. As a result, SierraRx Plus brand name drug coverage through the Part D gap made the plan particularly attractive to beneficiaries with HIV. Among the beneficiaries Sierra disenrolled effective March 1, 2007 were over 2,300 beneficiaries with HIV/AIDS. This information was brought to CMS' attention by AIDS Drug Assistance Programs (ADAPs) in Louisiana, Texas, Alabama, Oklahoma, Oregon, Colorado, Virginia, Delaware, Georgia, and the District of Columbia. These organizations pay Part D premiums on behalf of their clients. Despite paying or attempting to make arrangements to pay premiums on behalf of their clients, ADAPs learned that many of their clients were disenrolled from SierraRx Plus on March 1, 2007. Again, when CMS directed Sierra to reinstate these beneficiaries, Sierra refused. 3. Failure to afford beneficiaries the proper grace period prior to disenrolling beneficiaries for failure to pay premiums. The Medicare Part D regulations require Part D sponsors to make reasonable efforts to collect the unpaid premium amount. (42 CFR §423.44(d)(1)(i)) CMS' Medicare Part D enrollment guidance requires Part D sponsors tc afford enrollees a payment grace period of at least one month after a premium payment is due before involuntarily disenrolling a beneficiary. Sierra stated in the 2007 evidence of coverage (EOC) provided to its SierraRx Plus enrollees in January 2007 that beneficiaries would be afforded a three month grace period after the premium due date before Sierra would disenroll them for premium nonpayment. In late payment notices for February dated February 8, 2007, Sierra notified certain SierraRx Plus enrollees that they would be disenrolled at the end of February if they failed to make payment, a practice inconsistent with Sierra's previously announced three month grace period policy. Sierra also issued to all its SierraRx Plus members in late February 2007 a notice stating that they had reduced the payment grace period from three months to one. While the Part D enrollment guidelines allow sponsors to change their grace period, Sierra changed the duration of its grace period after affected beneficiaries began relying on the three month grace period. It is unfair for a sponsor to reduce significantly the amount of time beneficiaries may take to become current on their premium payments once they had been assured they could take up to three months to make full payment. On March 1, 2007, Sierra involuntarily disenrolled beneficiaries who had not paid their February premiums without affording them the benefit of the three month grace period. CMS requests that Sierra submit a proposed CAP within 14 days of the date of this letter. The CAP should provide Sierra's analysis of how the deficiencies occurred and what policies and procedures will be put in place to ensure that Sierra comes into and remains in compliance with its PDP sponsor contract. CMS will consider Sierra to be meeting Part D requirements only after it has demonstrated full compliance with Part D requirements for three consecutive months.	Closed

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Capital BlueCross	1-717-541-6113	S8067	Part D	Ad-Hoc Compliance Event	8/7/2007	Closed	Chapter 99: Ad-Hoc Compliance Event	Ad-Hoc Compliance Event 1	This letter is a request by the Centers for Medicare and Medicaid Services (CMS) for a plan for corrective action by Avalon Insurance Company (Avalon) to address two Medicare Part D compliance issues for Prescription Drug Plan (PDP) Sponsor contract S#8067. The first issue is improper enrollment of actively-employed beneficiaries into an employer group/union-only (800 series) plan, and the second issue is failure to submit payment certifications to CMS in a timely manner. I. Improper Enrollment On July 5, 2006, Avalon notified CMS via email that it may have enrolled actively employed beneficiaries into an employer group/union-only plan. On September 19, 2006, Avalon confirmed it had 1,413 actively employed members in Group SecureRx. Pursuant to CMS guidance Additional Part D Waive Guidance for Employer/Union Retiree Coverage April 6, 2005, available at www.cms.hhs.gov/EmpGrpWaivers/Downloads/PartDEmpUnionWaiverGuidance040605 Revl.pdf, an employer or union-sponsored PDP may only be offered to retirees. Additionally, the Employer/Union-Only Group Part D Addendum to Avalon's 2006 S8067 contract expressly states in Article II, Section A. 1., PDP Sponsor agrees to restrict enrollment in an employer/union-only group PDP to those eligible individuals eligible for the employer's/union's employment-based retiree prescription drug coverage (emphasis added). CMS is analyzing several options for how to move the actively-employed beneficiaries into an eligible Part D plan, and CMS will continue to work with Avalon to develop a viable solution for these beneficiaries. Going forward, to ensure that Avalon conducts 800 series plan waivers properly, CMS requests that Avalon provide its policies and procedures for ensuring the limitation of enrollment into S#8067, plan 801, strictly to retirees. CMS expects Avalon to continue to update Linda Gousis, Avalon's PDP Account Manager, with the number of actively-employed beneficiaries enrolled in the plan until all beneficiary enrollment surveys are returned. Linda can be reached via email at linda.gousiscms.hhs.gov or via phone at (410) 312-5272. II. Certification of Enrollment and Payment Information As of October 26, 2006, CMS records (maintained by its contractor, IntegriGuard) indicate that Avalon failed to submit required certifications for contract S#8067 for July, August, and September 2006 enrollment and payment data. Also, all certifications for 2006 data have been submitted late. Pursuant to 42 CFR §423.505(k)(2), Part D Sponsors must submit a Certification of Enrollment and Payment Information to CMS as a condition for receiving monthly payment. On March 30, 2006 CMS released a guidance memo through the Health Plan Management System (HPMS) entitled Certification of Monthly Enrollment and Payment Data, which requests PDPs to complete a certification and submit it each month. The certification for each month's data is due to CMS within 45 days of the date the reports for that month's data become available. In the future, CMS expects Avalon to submit certifications in a timely manner. III. Corrective Action CMS requests that Avalon Insurance Company submit (1) policies and procedures for ensuring proper employer/union-only group PDP enrollment, and (2) policies and procedures for ensuring certifications of enrollment and payment information are submitted timely. Please submit materials by December 15, 2006 at 5:00 p.m. to: Scott Nelson Medicare Drug Benefit Group Centers for Medicare and Medicaid Services	Closed

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									7500 Security Blvd., Mail Stop C 1-26-12 Baltimore, MD 21244-1850 If you have any questions, please contact Scott Nelson at (410) 786-1038. Sincerely, Cynthia G. Tudor, Ph.D. Director Medicare Drug Benefit Group	
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	APIPA must revise its policies and procedures to include the requirements noted in the deficiency above.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	APIPA must revise its policies and procedures to include the missing requirement noted above and submit a copy of the revised policy and procedure to CMS.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	APIPA must revise its policies and procedures to include the provision noted above and resubmit the revised version to CMS as part of its CAP.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	APIPA must develop a policy and procedure for contracting with LTC pharmacies that includes the missing provision noted in the finding above.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	APIPA must revise its policies and procedures to include the provisions noted above and submit them to CMS as part of its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	APIPA must revise its policies and procedures to include the requirements discussed above and implement system reports as described above. APIPA must also conduct training of appropriate staff on these policies and procedures and system reports and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	APIPA must either submit documentation showing the number and percentage of network pharmacies it has audited to ensure that pharmacies are posting or distributing notices describing how members may obtain coverage determinations or request exceptions or it may develop a monitoring process and submit it along with a schedule to CMS with its CAP.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.566 (a-c) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 10.4.1, 10.4.2, and 10.5. APIPA must submit the revised policies and procedure to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.568 (a), § 423.568 (e), and § 423.578 (c)(2) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 40.2 and 40.4. APIPA must submit the revised policies and procedures to CMS with its CAP. APIPA must also correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe for WSCD_1 for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.568 (b) and § 423.568 (e). APIPA must submit the revised policies and procedures to CMS with its CAP. APIPA must develop procedures to make sure payments are made timely, and submit it with the CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.568 (c-d) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 40.3.3 and Appendix 1. APIPA must submit the revised policies and procedures to CMS with its CAP. APIPA must also correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe for WSCD_1 for the same review period, 9/1/06 through 2/28/07 as part of its CAP. APIPA must either provide a copy of their Notice of Denial of Medicare Prescription Drug Coverage that meets CMS requirements or develop a notice that meets these requirements, and submit it with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.540 (c)(3) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 50, 50.1 and 50.2. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.570 (d), § 423.572 (a) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 50.3. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.570 (d) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, Chapters 50.5 and 50.6. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.570 (e), § 423.572 (a-b), § 423.572 (d), § 423.578 (c)(2) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 50.6. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.572 (c) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 50.6 and Appendix 6. APIPA must submit the revised policies and procedure to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	APIPA must develop policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.578 (a)(1-2), § 423.578 (a)(4) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 30.2.1 and Appendix 11. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.578 (b), § 423.578 (b)(1), § 423.578(b)(2), § 423.578 (b)(5) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 30.2.2 and Appendix 11. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.578 (c)(3), § 423.578 (c)(4)(i-ii) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 30.2.2 and Appendix 11. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	APIPA must revise its policies and procedures to include the provision noted above and resubmit the revised version to CMS as its CAP. Refer to 42 CFR § 423.564 (b). APIPA must also correct its internal coding to make sure that cases are correctly coded and resubmit corrected universes for WSGV1_D and WSCD1_D for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	APIPA must update its policies and procedures to correct the above noted deficiency. Refer to the Medicare Part D Reporting Requirements Contract Year 2007, section IV to obtain this information. It must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	APIPA must update its policies and procedures to correct the above noted deficiency. The plan must develop and implement a training program and provide documentation of trainings. APIPA must submit the revised/new policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	APIPA must either revise or develop a new policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.564 (e)(1-2) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 20.3. APIPA must submit the revised policies and procedure to CMS with its CAP. APIPA must also correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe for WSGV1_D for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.564 (e)(3)(i-ii) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 20.3. APIPA must submit the revised policies and procedure to CMS with its CAP. APIPA must also correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe for WSGV1_D for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.564 (e)(3)(iii) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 20.2.1. APIPA must submit the revised policies and procedure to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.582 (a-b), § 423.586 and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 70, 70.2 and 70.5. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.584 (c)(1), § 423.586 and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 70.8 and 70.8.1. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.584 (c) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 70.8.1, Appendix 3 and Appendix 11. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.584 (d-e) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 70.8.1 and Appendix 3. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.590 (a)(1-2), § 423.590 (c), § 423.590 (g), § 423.636 (a)(1) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 70.7, 70.1 and 130.1. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.590 (b-c), § 423.590 (g)(1-4), § 423.636 (a)(2) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 130.2.3. APIPA must submit the revised policies and procedures to CMS with its CAP. APIPA must also correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe for WSRE2_D for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.584 (e), § 423.590 (d-e), § 423.638 (a) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 70.8.1. APIPA must submit the revised policies and procedures to CMS with its CAP. APIPA must either provide a copy of their notice "Request for Reconsideration" that meets CMS requirements or develop a notice that meets these requirements, and submit it with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.638 (a) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 130.2.2. APIPA must submit the revised policies and procedures to CMS along with a systems report or log with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to 42 CFR § 423.590 (f) and Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 70.6. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 70.20, 70.30 and Appendix 6. APIPA must submit the revised policies and procedures to CMS with its CAP. APIPA must also correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe for WSRE2_D for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 130.3.1and Appendix 9. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 130.3.3 and Appendix 9. APIPA must submit the revised policies and procedures to CMS with its CAP. APIPA must also correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe for WSRE2_D for the same review period, 9/1/06 through 2/28/07 as part of its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA-PD	Audit Findings	8/3/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	APIPA must revise its policies and procedures to address the above noted deficiencies. Refer to Chapter 18, Part D Enrollment Grievances, Coverage Determinations, and Appeals, 130.3.2 and Appendix 9. APIPA must submit the revised policies and procedures to CMS with its CAP.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Describe actions APIPA is taking to ensure meeting the written notice to Medicare members 30 days prior to the termination of his/her PCP in accordance with CMS policy and regulations. The process must include internal health plan audits to ensure compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	APIPA must describe the actions it is taking to ensure that it and its delegated entities credential/recredential contracted providers in accordance with CMS requirements, on a timely basis. Corrective action must include policy and procedure revisions for the health plan as well as its delegated entities. It must include internal health plan audits as well as delegation oversight audits of credentialing files to ensure compliance.	Closed

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UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	APIPA must describe the actions it is taking to ensure that it is meeting the member notification requirements for grievances in accordance with CMS policy and regulations. As part of the required corrective action, APIPA must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	APIPA must send CMS compliant notices (the standardized Notice of Denial of Payment) to members when it denies claims from non-contracted providers. The description of denied services and the denial reasons used with the notice must be clear and understandable. As part of the required corrective action, APIPA must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	APIPA must describe the actions it is taking to ensure that interest paid on clean claims from non-contracted providers is in accordance with CMS policy and regulations. As part of the required corrective action, APIPA must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	APIPA must send CMS compliant notices (the standardized Notice of Denial of Payment) to members when it denies claims from non-contracted providers. The description of denied services and the denial reasons used with the notice must be clear and understandable. As part of the required corrective action, APIPA must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions APIPA is taking to ensure it is meeting the timeliness standards for standard pre-service organization determinations in accordance with CMS policy and regulations. The process must include internal health plan audits to ensure compliance with CMS requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	APIPA must describe the actions it is taking to ensure that the NDMC contains denial reasons that are specific, clear and easily understood by the beneficiary in accordance with CMS policy and regulations. Corrective action must include internal health plan audits to ensure compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Organization Determination Requests - The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.	Describe actions APIPA is taking to ensure that it has a process for expedited organization determination requests. The corrective action must include policies and procedures, flow charts, appropriate notices and member notification. The process must include internal health plan oversight audits to ensure compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Submit to CMS a universe for Requests for Expedited Organization Determinations from June 1, 2006 to August 31, 2007. See Appendix 1-Model #5a, Enclosure I from the CMS letter to APIPA dated April 12, 2007 for a universe description.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Submit to CMS a universe for Requests for Expedited Organization Determinations from June 1, 2006 to August 31, 2007. See Appendix 1-Model #5a, Enclosure I from the CMS letter to APIPA dated April 12, 2007 for a universe description.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	Describe actions APIPA is taking to ensure that it has a process for expedited organization determination requests. The corrective action must include policies and procedures, flow charts, appropriate notices and member notification. The process must include internal health plan oversight audits to ensure compliance with CMS requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	Describe actions APIPA is taking to ensure that it has a process for expedited organization determination requests. The corrective action must include policies and procedures, flow charts, appropriate notices and member notification. The process must include internal health plan oversight audits to ensure compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	Submit to CMS a universe for Requests for Expedited Organization Determinations from June 1, 2006 to August 31, 2007. See Appendix 1-Model #5a, Enclosure I from the CMS letter to APIPA dated April 12, 2007 for a universe description.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	APIPA must describe the measures it is taking to ensure that it notifies members of favorable claims reconsideration decisions within CMS required timeframes. As part of the required corrective action, APIPA must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	APIPA must describe the measures it is taking to ensure that it notifies members of adverse claims reconsideration decisions within CMS required timeframes. As part of the required corrective action, APIPA must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	APIPA must describe the measures it is taking to ensure that when a determination is reversed by the IRE, that APIPA will pay for the services within CMS required timeframes and notify the IRE that it has effectuated the decision. As part of the required corrective action, APIPA must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	APIPA must generate a new universe for WSRP1 (favorable standard pre-service reconsiderations) and submit it to CMS for further action. Since there are potentially so few cases in the original universe to consider, the review period for the new universe is changed to 9/1/2006 through 6/30/2007 for this sample. Please refer to Enclosure IV of the 4/12/2007 letter from CMS confirming the site visit for details about the universe and submission format.	Closed
UnitedHealth Group, Inc.	1-602-664-5483	H0321	MA	Audit Findings	8/3/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	APIPA must describe the actions it is taking to ensure that it 1) forwards adverse standard pre-service reconsiderations to the IRE within the CMS required timeframe when it is unable to fully reverse its own decisions, and 2) notifies effected members concurrently that it is forwarding their case to the IRE for a final reconsideration decision. As part of the required corrective action, APIPA must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	For all future plan year 2007 negative formulary changes that become effective on or after 6/1/07, CareOregon must provide CMS with documentation that demonstrates 1) the effective date of the negative formulary change and 2) the date that notification of the negative change was posted to CareOregon¿s provider website formulary change page. This documentation must show that CareOregon is providing the required 60 day prior notification to all authorized prescribers, network pharmacies, and pharmacists.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	CareOregon must revise its policies and procedures (P and T Committee and Formulary Management.doc) to address the requirement to provide notification of negative formulary changes to entities providing other prescription drug coverage. Specifically, CareOregon's policies and procedures must address 60-day prior notification of entities providing other prescription drug coverage for "maintenance" formulary changes and "other" formulary changes, and the provision of retrospective notice to entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. For a definition of "formulary maintenance changes" and "other formulary changes," please refer to Chapter 6 of the Prescription Drug Benefit Manual, Section 30.3. CMS has not issued any specific guidance on appropriate notification methods Part D sponsors must use to meet this requirement. Notification method(s) must include, at a minimum, posting formulary changes on CareOregon's Internet website.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	CareOregon must provide CMS with a copy of the signed long-term care pharmacy addendum for its pharmacy with the code 905. CareOregon must also provide CMS with a contract for its pharmacy with the code 307 that includes the appropriate effective dates.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	CareOregon must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. CareOregon must also revises its policies and procedures to include a provision for arranging with its network pharmacies to post or distribute the "Medicare Prescription Drug Coverage and Your Rights" notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CareOregon must demonstrate that its network pharmacies are posting or distributing the "Medicare Prescription Drug Coverage and Your Rights" notice. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CareOregon must revise its policies and procedures to include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination that requires the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CareOregon must provide documentation to CMS that demonstrates it forwards coverage determinations to the IRE within 24 hours of the expiration of the adjudication timeframe when they were not determined timely.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	CareOregon must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) CareOregon must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (2) CareOregon must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and (3) failure to notify the enrollee within the timeframe constitutes an adverse coverage determination that requires CareOregon to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CareOregon must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	CareOregon must revise its policies and procedures to include a telephone number of the designated office and/or department that receives both oral and written requests. CareOregon must also revise its policies and procedures to include a provision stating that all oral requests must be documented in writing and that documentation of each request must be maintained in a case file. CareOregon must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CareOregon must revise its policies and procedures to include the following: (1) a provision stating that CareOregon will notify the enrollee of its decision on an expedited coverage determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, after receipt of the physician's supporting statement, (2) a provision stating that if a decision is adverse and CareOregon first notifies the enrollee of the determination orally, CareOregon must mail written confirmation to the enrollee within 3 calendar days of the oral notification, (3) a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse coverage determination requiring CareOregon to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and (4) a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CareOregon must provide documentation to CMS demonstrating that it informs enrollees, within 24 hours, when their cases are forwarded to the IRE.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	CareOregon must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. CareOregon must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	CareOregon must revise its policies and procedures to include a provision stating that if CareOregon makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CareOregon must provide CMS with a CMS-approved notice template that is consistent with the CMS-issued Request for Additional Information. If CareOregon does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	CareOregon must revise its policies and procedures to include a provision stating that enrollees are not required to request an approval following the initial prescription for the remainder of the plan year. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	CareOregon must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If CareOregon does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. CareOregon must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CareOregon must provide documentation to CMS that demonstrates it has a means for informing enrollees whether their complaints are subject to grievance or coverage determination procedures. CareOregon must provide documentation to CMS that demonstrates it notifies enrollees whether their complaints are subject to grievance or coverage determination procedures, per CMS requirements.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	CareOregon must revise its policies and procedures to ensure they include a provision requiring prompt and appropriate action regarding a grievance. Policies and procedures must also include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. Lastly, policies and procedures must be revised to include a provision for quarterly reporting all data requested in the CMS Reporting Requirements Section V: Grievances. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	CareOregon must develop policies and procedures regarding grievance process training that contain a provision for training relevant staff and contractors on grievance policies and procedures. CareOregon must conduct training of appropriate staff and contractors (if applicable) on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CareOregon must provide documentation demonstrating that it has and implements training on grievance policies and procedures for staff and contractors (if applicable).	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	CareOregon must revise its policies and procedures to ensure they include a provision stating that all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status. Policies and procedures must also include a provision stating that the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if the Part D sponsor justifies a need for additional information and documents how the delay is in the interest of the enrollee, as well as a provision stating that the enrollee must immediately be notified in writing when the Part D sponsor extends the deadline. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CareOregon must provide documentation to CMS that demonstrates it addresses enrollee grievances fully and within the timeframes required by CMS.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	CareOregon must provide documentation to CMS that demonstrates it responds to enrollee grievances in accordance with CMS requirements.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	CareOregon must update its policies and procedures to remove reference to the AGC when describing its commitment to cooperating with the QIO in resolving grievance cases. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	CareOregon must update its policies and procedures to ensure they include a provision stating that CareOregon must respond within 24 hours to the enrollee's expedited grievance if the complaint involves a refusal by CareOregon to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased the drug that is in dispute. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	CareOregon must revise its policies and procedures to include a telephone number for receiving oral requests for redeterminations. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	CareOregon must revise its policies and procedures to include provisions stating that: - The decision to accept or deny an expedited redetermination request is based on the enrollee's request indicating that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, and - Any additional medical information CareOregon requires must be requested within 24 hours of receiving the initial request for an expedited redetermination. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	CareOregon must revise its policies and procedures to include provisions stating that: - CareOregon must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - CareOregon must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. CareOregon must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. CareOregon must provide CMS with a CMS-approved notice template that is consistent with the CMS-issued Notice of Right to an Expedited Grievance. If CareOregon does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CareOregon must revise its policies and procedures to include a provision stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination. CareOregon must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CareOregon must provide CMS with documentation demonstrating that CareOregon provides enrollees with the notice, Request for Reconsideration, for denied redeterminations concerning drug benefit.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CareOregon must revise its policies and procedures to include provision stating that: - For favorable redeterminations to the enrollee (concerning payment), CareOregon must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. - Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring CareOregon to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CareOregon must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CareOregon must revise its policies and procedures to include provisions stating that: - Medical information must be requested within 24 hours of the enrollee's initial request, - Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring CareOregon to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - CareOregon must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. CareOregon must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	CareOregon must revise its policies and procedures to include a provision stating that: - Payment must be authorized within 72 hours from the date CareOregon receives notice reversing the decision, and - Payment must be made no later than 30 days from the date CareOregon receives notice reversing the decision. CareOregon must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	CareOregon must update its policies and procedures to include a provision that states that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. CareOregon must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: -a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, `or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of 'maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: -a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: -State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, -Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and -Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: -a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and -a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: -a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: -a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

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Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S2874	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, `or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5552	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must demonstrate to CMS that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses Humana's redetermination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of third party reversals of an expedited request for benefit that were received from Maximus that month, the number of these reversals that Humana effectuated, the number of these effectuations that were made in the CMS required timeframe, and the number of times Humana notified Maximus that it made the effectuation.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, 'or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open

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Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

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Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must demonstrate to CMS that it effectuates third party reversals for standard drug benefit cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses Humana's redetermination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of third party reversals of a standard request for benefit that were received from Maximus that month, the number of these reversals that Humana effectuated, the number of these effectuations that were made in the CMS required timeframe, and the number of times Humana notified Maximus that it made the effectuation.	Closed
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must demonstrate to CMS that it effectuates third party reversals for payment cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses Humana's redetermination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of third party reversals of a standard request for payment that were received from Maximus that month, the number of these reversals that Humana effectuated, the number of these effectuations that were made in the CMS required timeframe, and the number of times Humana notified Maximus that it made the effectuation.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	S5884	Part D	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must demonstrate to CMS that it effectuates third party reversals for expedited drug benefit cases within the timeframes required by CMS and that it notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses Humana's redetermination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of third party reversals of an expedited request for benefit that were received from Maximus that month, the number of these reversals that Humana effectuated, the number of these effectuations that were made in the CMS required timeframe, and the number of times Humana notified Maximus that it made the effectuation.	Open
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, `or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy amd Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

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Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

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Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H1407 (Consolidation)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, `or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of `maintenance¿ formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must demonstrate to CMS that it effectuates third party reversals for standard drug benefit cases within the timeframes required by CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of third party reversals of a standard request for benefit that were received from Maximus that month, the number of these reversals that Humana effectuated, the number of these effectuations that were made in the CMS required timeframe, and the number of times Humana notified Maximus that it made the effectuation.	Closed
Humana Inc.	1-502-580-3683	H1804	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, `or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H0307	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, `or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, 'within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination 'as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe 'constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe 'constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, 'within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe 'constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, 'within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

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Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently	Closed
Humana Inc.	1-502-580-3683	H1036	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, `or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open

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Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.	Closed

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Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

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Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee¿s complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

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Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	R5826	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

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Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, "or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed" at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of 'maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, "within 24 hours" must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.	Closed

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Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination "as expeditiously as the enrollee's health condition requires" or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe "constitutes an adverse redetermination" requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

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Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe "constitutes an adverse redetermination decision" requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, "within 24 hours," when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe "constitutes an adverse redetermination decision" requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, "within 24 hours," when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H5657	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: 'The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan.' Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: - a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, "or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed" at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of 'maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee¿s prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed

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Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: - a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, "within 24 hours" must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: - State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.	Closed

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Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, "Notice of Inquiry Regarding an Excluded Drug"). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, "Notice of Inquiry Regarding an Excluded Drug"), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: - a provision for effectuating the favorable redetermination "as expeditiously as the enrollee's health condition requires" or within 7 calendar days from the date it received the request for a standard redetermination, and - a provision stating that failure to notify the enrollee within the timeframe "constitutes an adverse redetermination" requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe "constitutes an adverse redetermination decision" requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, "within 24 hours," when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: - a provision stating that failure to notify the enrollee within the timeframe "constitutes an adverse redetermination decision" requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and - a provision stating that Humana must inform the enrollee, "within 24 hours," when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H1406	MA-PD	Audit Findings	7/31/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Humana submitted to the audit team a policy and procedure (Formulary Change Notification During a Plan Year 2007-003) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for this element.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Humana must revise its policies and procedures regarding its responsibility for and oversight of persons employed or contracted to perform marketing to contain a requirement that any person directly employed or contracted to market on behalf of Humana provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment which states the following: `The person that is discussing plan options with you is either employed by or contracted with Humana. The person may be compensated based on your enrollment in a plan. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with documentation that its marketing program monitoring activities confirm that Humana's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents.	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include the following: -a provision to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective,`or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed' at the time a refill is requested, and are provided written notice of the formulary change. Specifically, the language in quotation marks must be added to the policy. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Humana submitted to the audit team policies and procedures dated post-audit period that do not include all of the required provisions. Humana must revise its policies and procedures regarding beneficiary notification of formulary changes (Formulary Change Notification During a Plan Year 2007-003) to include a provision with a description of the procedures for providing a notice of `maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. Humana must provide to CMS policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Appeals. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana submitted to the audit team a policy and procedure (Standard Coverage Determinations) dated post-audit period that includes the required provisions. Therefore, no corrective action is required for the first deficiency listed for this element. However, because Humana staff treat all coverage determinations as exceptions requests and begin the timeframe when the supporting statement is received from the physician, Humana must conduct training of appropriate staff on these new policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must always notify the enrollee of its coverage determination concerning drug benefit decisions and provide documentation of this to CMS. Additionally, Humana must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS. Humana must notify the enrollee (and the prescribing physician, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, Humana must send the written notice to the enrollee within 3 calendar days of the oral notice. Additionally, when the prescribing physician files a request on behalf of an enrollee, Humana must notify the enrollee and the enrollee's prescribing physician of the coverage determination decision. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of coverage determination concerning drug benefit requests received by Humana that month, the number of coverage determination decisions that were adverse, the number of coverage determination decisions that were favorable, the number of coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Humana must create policies and procedures regarding enrollee notification of coverage determinations to include provisions concerning payment. Specifically, the following provisions are required by CMS: -a provision stating that Humana must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, -a provision stating that Humana must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and -a provision stating that Humana must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	When Humana makes an adverse standard coverage determination concerning drug benefit decision, it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage, that contains the required OMB control number displayed in the upper right-hand corner of the notice. Humana must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must modify its policies and procedures regarding enrollee notification following a decision on an expedited coverage determination to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Specifically, `within 24 hours' must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must notify enrollees of its expedited coverage determination decisions in a timeframe that is compliant with CMS requirements and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage determination requests received by Humana that month, the number of expedited coverage determination decisions that were adverse, the number of expedited coverage determination decisions that were favorable, the number of expedited coverage determination decisions that were made within the CMS approved timeframe, and how many times the enrollee was notified of the decision.	Open
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Humana must revise its policies and procedures regarding enrollee notification following a decision on expedited coverage determination to include a provision stating that if oral notice is provided for an adverse decision, the notices must satisfy the following requirements: -State the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, -Provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and -Provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must also provide documentation to CMS demonstrating that it is using this notice when informing enrollees of its expedited coverage determination decisions.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Humana must revise its policies and procedures (HCPR056) regarding determining cost-sharing for approved exceptions to include a provision stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Humana must demonstrate, and provide documentation of this to CMS, that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Humana must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If Humana does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payment, contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Humana must provide to CMS its policies and procedures regarding reporting requirements for grievances data elements to include a provision for quarterly reporting of all data requested in Part D Reporting Requirements: Grievances. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contained misclassified samples. Based on the analysis, Humana must provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Humana must revise its policies and procedures for accepting requests for standard redeterminations to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. To clarify, the enrollee has the right to submit evidence related to the redetermination request in person or in writing. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit to include the following: -a provision for effectuating the favorable redetermination `as expeditiously as the enrollee's health condition requires' or within 7 calendar days from the date it received the request for a standard redetermination, and -a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Specifically, the language in quotation marks must be added to the provisions in the policy and procedure document Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS). Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must forward untimely standard redetermination concerning drug benefits decisions to the IRE as required by CMS and provide documentation of this to CMS.	Closed

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Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment to include a provision stating that for redeterminations favorable to the enrollee, Humana must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. Additionally, Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: -a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision' requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Humana must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (Policy and Procedure #37 Reconsideration Independent Review Entity (MAXIMUS)) to include: -a provision stating that failure to notify the enrollee within the timeframe `constitutes an adverse redetermination decision¿ requiring Humana to forward the enrollee's complete file to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -a provision stating that Humana must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. Specifically, the language in quotation marks must be added. Humana must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide CMS with a CMS-approved notice template for requesting a reconsideration that is consistent with CMS-issued model notice, Request for Reconsideration. If Humana does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Humana must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Humana must provide the enrollee with CMS approved notices when informing an enrollee of an adverse expedited coverage redeterminations decision. Specifically, Humana must use the Notice of Redetermination and the Request for Reconsideration and provide documentation of this to CMS. Humana must always notify the enrollee of its expedited redetermination concerning drug benefit decisions and provide documentation of this to CMS. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited redetermination requests received by Humana that month, the number of expedited redetermination decisions that were favorable, the number of expedited redetermination decisions that were adverse, and the number of times the enrollee was notified of the decision. Humana must forward untimely expedited coverage redetermination decisions to the IRE within 24 hours of the expiration of the adjudication timeframe. Humana must track its performance in this area and provide a monthly summary report to CMS, until further notice. This monthly report should present results in a table format and should include at least the following information: the number of expedited coverage redetermination decisions that were untimely, the number of untimely decisions in which the case was forwarded to the IRE, and the number of cases sent to the IRE within 24 hours of the expiration of the adjudication timeframe.	Closed

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Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	When the IRE requests a case file from Humana, Humana must transfer the requested file to the IRE in a timeframe that is consistent with CMS requirements and provide documentation of this to CMS. Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently	Closed
Humana Inc.		H5683 (Withdrawn Contract)	MA-PD	Audit Findings	7/31/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Humana must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contained misclassified cases. Based on the analysis, Humana is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Humana Inc.	1-502-580-3683	H0307	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan's Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.	Closed
Humana Inc.	1-502-580-3683	H0307	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly report to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, (3) better oversee agent/broker licenses and appointments for the states they sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are completed in a timely fashion after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.	Closed
Humana Inc.	1-502-580-3683	H0307	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	H0307	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	H0307	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed

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Humana Inc.	1-502-580-3683	H0307	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	None required.	Closed
Humana Inc.	1-502-580-3683	H1036	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan's Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.	Closed
Humana Inc.	1-502-580-3683	H1036	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.	Closed
Humana Inc.	1-502-580-3683	H1036	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly report to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, (3) better oversee agent/broker licenses and appointments for the states they sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are completed in a timely fashion after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1036	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	H1036	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	H1036	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	H1036	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	None required.	Closed
Humana Inc.	1-502-580-3683	H1406	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan's Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.	Closed
Humana Inc.	1-502-580-3683	H1406	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1406	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly report to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, (3) better oversee agent/broker licenses and appointments for the states they sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are completed in a timely fashion after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.	Closed
Humana Inc.	1-502-580-3683	H1406	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	H1406	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	H1406	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed

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Humana Inc.	1-502-580-3683	H1406	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	None required.	Closed
Humana Inc.		H1407 (Consolidation)	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials - For "non-model" documents and for "model" documents that the M+CO modifies: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 45 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.For "model" documents that the M+CO uses without modification: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 10 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.	Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan¿s Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.	Closed
Humana Inc.		H1407 (Consolidation)	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The M+CO establishes and maintains a marketing system for confirming that enrolled members understand that they are enrolled in the M+C plan, and understand the rules applicable under the plan.	Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.	Closed

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Humana Inc.		H1407 (Consolidation)	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly reports to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, but especially private-fee-for-service (PFFS) plans where the majority of the complaints are centered, (3) better oversee agent/broker licenses and appointments for the states where sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are competed in a timely fashion with the recommendation that they be completed after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.	Closed
Humana Inc.		H1407 (Consolidation)	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	Humana must provide documentation to enable CMS to determine that the necessary steps are taken to ensure that all claim determinations are appropriate.	Closed
Humana Inc.		H1407 (Consolidation)	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Timely Payment of Non-Contracting Provider Clean Claims - The M+CO must pay 95 percent of "clean" claims from all providers within 30 calendar days of receipt.	Humana must provide documentation to support what steps are being taken to ensure that this CMS requirement is met. Since these claims were processed by PGBA, you should provide documentation of how you will maintain oversight of this delegated entity.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H1407 (Consolidation)	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize the service within 72 hours from the date it receives the notice reversing the determination, provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date), or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal, or pay the claim following the plan's normal claims processing procedures.	Plan must implement a process to ensure that Third Part Standard Pre-Service Reconsiderations Reversals are effected timely.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.		H1407 (Consolidation)	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Requests for Expedited Reconsiderations (Timeliness) - The M+CO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the M+CO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the M+CO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the M+CO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified), or pay the claim following the plan's normal claims processing procedures. If the M+CO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the M+CO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the M+CO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the M+CO must submit the file to CMS's independent review entity within 24 hours. The M+CO must concurrently notify the member in writing that it has forwarded the case file to CMS's independent review entity.	Humana must demonstrate that it authorizes and communicates on requests for expedited reconsiderations. Humana should provide a formal policy and procedure and proof of educated staff on the process to authorize and communicate on requests for expedited reconsiderations.	Closed

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Humana Inc.		H1407 (Consolidation)	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Effectuation of Third Party Expedited Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination, or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal, or pay the claim following the plan's normal claims processing procedures.	Plan must demonstrate that when a determination is reveresed in whole or in part by the independent review entity, that Humana authorizes and provides the service under dispute as expeditiously as the member's health rquired but no later than 72 hours after the date it recieves notice reversig the determination. Then Humana must inform the IRE that that Humana has effectuated the decision. Humana should provide proof of the correct implementation of these processes and evidence that the staff has been education to handle these cases correctly.	Closed
Humana Inc.	1-502-580-3683	H1804	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials - For "non-model" documents and for "model" documents that the M+CO modifies: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 45 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.For "model" documents that the M+CO uses without modification: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 10 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.	Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan¿s Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.	Closed
Humana Inc.	1-502-580-3683	H1804	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The M+CO establishes and maintains a marketing system for confirming that enrolled members understand that they are enrolled in the M+C plan, and understand the rules applicable under the plan.	Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly reports to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, but especially private-fee-for-service (PFFS) plans where the majority of the complaints are centered, (3) better oversee agent/broker licenses and appointments for the states where sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are competed in a timely fashion with the recommendation that they be completed after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.	Closed
Humana Inc.	1-502-580-3683	H1804	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	Humana must provide documentation to enable CMS to determine that the necessary steps are taken to ensure that all claim determinations are appropriate.	Closed
Humana Inc.	1-502-580-3683	H1804	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Timely Payment of Non-Contracting Provider Clean Claims - The M+CO must pay 95 percent of "clean" claims from all providers within 30 calendar days of receipt.	Humana must provide documentation to support what steps are being taken to ensure that this CMS requirement is met. Since these claims were processed by PGBA, you should provide documentation of how you will maintain oversight of this delegated entity.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize the service within 72 hours from the date it receives the notice reversing the determination, provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date), or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal, or pay the claim following the plan's normal claims processing procedures.	Plan must implement a process to ensure that Third Part Standard Pre-Service Reconsiderations Reversals are effected timely.	Closed

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Humana Inc.	1-502-580-3683	H1804	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Requests for Expedited Reconsiderations (Timeliness) - The M+CO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the M+CO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the M+CO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the M+CO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified), or pay the claim following the plan's normal claims processing procedures. If the M+CO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the M+CO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the M+CO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the M+CO must submit the file to CMS's independent review entity within 24 hours. The M+CO must concurrently notify the member in writing that it has forwarded the case file to CMS's independent review entity.	Humana must demonstrate that it authorizes and communicates on requests for expedited reconsiderations. Humana should provide a formal policy and procedure and proof of educated staff on the process to authorize and communicate on requests for expedited reconsiderations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1804	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Effectuation of Third Party Expedited Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination, or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal, or pay the claim following the plan's normal claims processing procedures.	Plan must demonstrate that when a determination is reveresed in whole or in part by the independent review entity, that Humana authorizes and provides the service under dispute as expeditiously as the member's health rquired but no later than 72 hours after the date it recieves notice reversig the determination. Then Humana must inform the IRE that that Humana has effectuated the decision. Humana should provide proof of the correct implementation of these processes and evidence that the staff has been education to handle these cases correctly.	Closed
Humana Inc.	1-502-580-3683	H5657	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials - For "non-model" documents and for "model" documents that the M+CO modifies: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 45 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.For "model" documents that the M+CO uses without modification: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 10 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.	Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan¿s Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.	Closed
Humana Inc.	1-502-580-3683	H5657	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The M+CO establishes and maintains a marketing system for confirming that enrolled members understand that they are enrolled in the M+C plan, and understand the rules applicable under the plan.	Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly reports to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, but especially private-fee-for-service (PFFS) plans where the majority of the complaints are centered, (3) better oversee agent/broker licenses and appointments for the states where sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are competed in a timely fashion with the recommendation that they be completed after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.	Closed
Humana Inc.	1-502-580-3683	H5657	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	Humana must provide documentation to enable CMS to determine that the necessary steps are taken to ensure that all claim determinations are appropriate.	Closed

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Humana Inc.	1-502-580-3683	H5657	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize the service within 72 hours from the date it receives the notice reversing the determination, provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date), or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal, or pay the claim following the plan's normal claims processing procedures.	Plan must implement a process to ensure that Third Part Standard Pre-Service Reconsiderations Reversals are effected timely.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H5657	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Requests for Expedited Reconsiderations (Timeliness) - The M+CO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the M+CO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the M+CO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the M+CO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified), or pay the claim following the plan's normal claims processing procedures. If the M+CO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the M+CO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the M+CO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the M+CO must submit the file to CMS's independent review entity within 24 hours. The M+CO must concurrently notify the member in writing that it has forwarded the case file to CMS's independent review entity.	Humana must demonstrate that it authorizes and communicates on requests for expedited reconsiderations. Humana should provide a formal policy and procedure and proof of educated staff on the process to authorize and communicate on requests for expedited reconsiderations.	Closed

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Humana Inc.	1-502-580-3683	H5657	MA	Audit Findings	7/30/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Effectuation of Third Party Expedited Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination, or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal, or pay the claim following the plan's normal claims processing procedures.	Plan must demonstrate that when a determination is reveresed in whole or in part by the independent review entity, that Humana authorizes and provides the service under dispute as expeditiously as the member's health rquired but no later than 72 hours after the date it recieves notice reversig the determination. Then Humana must inform the IRE that that Humana has effectuated the decision. Humana should provide proof of the correct implementation of these processes and evidence that the staff has been education to handle these cases correctly.	Closed
Humana Inc.	1-502-580-3683	R5826	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan's Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.	Closed
Humana Inc.	1-502-580-3683	R5826	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	R5826	MA	Audit Findings	7/30/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly report to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, (3) better oversee agent/broker licenses and appointments for the states they sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are competed in a timely fashion with the recommendation that they be completed after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.	Closed
Humana Inc.	1-502-580-3683	R5826	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	R5826	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan.	Closed
Humana Inc.	1-502-580-3683	R5826	MA	Audit Findings	7/30/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	(1) Humana must submit the final version of its Transition Plan, including copies of the revised provider contract templates and amendments. (2) Humana must submit a monthly report to track the progress of the Transition Plan implementation. (3) Humana must implement all provisions contained in the Transition Plan	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Blue Care Network must develop and implement policies and procedures that include a provision to notify network pharmacies and pharmacists of negative formulary changes. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Blue Care Network must revise its policies and procedures to include a provision with a description of the procedures for providing a notice of maintenance formulary changes to CMS, SPAPs and entities providing prescription drug coverage. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	P&T Committee Membership - The Part D sponsor¿s P&T Committee must include a majority of members who are practicing physicians and/or practicing pharmacists; include at least one practicing physician and at least one practicing pharmacist who are independent and free of conflict with the Part D plan organization and pharmaceutical manufacturers; and include at least one practicing physician and one practicing pharmacist who are experts regarding care of elderly or disabled individuals.	Blue Care Network must revise its policies and procedures on P and T Committee membership to include a provision requiring the inclusion of one practicing physician and one practicing pharmacist who are experts regarding the care of the elderly or disabled. They should also define the term "expert" within the policy. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Blue Care Netowrk must develop and implement policies and procedures that put a provision in place for the posting and distribution of the notice instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist in the long term care setting. They need to include the provision in their contracts for network pharmacies (retail, home infusion, long-term care and I/T/U) to post the notice. Blue Care Network also must monitor pharmacies for compliance with the distribution and posting of notices. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Blue Care Network must revise its policies and procedures regarding coverage determinations to include "the enrollee's appointed representative" in the section stating who may request a standard or expedited coverage determination. In addition, the sponsor needs to document any oral notification between the plan and the enrollee, enrollee's representative or the physician. They should incorporate the oral notification into their policies and procedures. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Blue Care Network should establish a mechanism for monitoring in this area to ensure they are able to evaluate timely notification of coverage determination concerning payment.	Closed

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Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Blue Care Network should establish a mechanism for ongoing monitoring in this area to ensure they are able to evaluate if the notice is compliant for denial notice requirements for coverage determinations.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Blue Care Network must develop and implement policies and procedures that address timeframes for enrollee notification following a decision to deny a request for an expedited coverage determination. They a lso need to include a provision stating that an oral and written notice must inform the enrollee: the right to file an expedited grievance, the right to resubmit a request for an expedited determination with the prescribing physician's support, instructions about the plan's grievance process and timeframes. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Blue Care Network must revise its policies and procedures to include a provision in their policies and procedures regarding enrollee notification following a decision on expedited coverage determinations. This includes: if the decision is adverse, the sponsor must use a notice consistent with a CMS standard notice and a provision stating that if oral notice is provided for an adverse decision, the reason for denial, the right to file an appeal and explanation of the redetermination process and the rest of the appeals process must be provided to the beneficiary. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Blue Care Network must revise its policies and procedures to include the ability for an enrollee's appointed respresentative to request a tiering exception on their behalf. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Blue Care Network must revise its policies and procedures to include a provision allowing for an enrollee¿s appointed representative to file a request for a non-formulary exception. They must also include a provision that the Sponsor must wait a minimum of 96 hours for a supporting statement from a physician prior to making a decision for a standard exception request or 48 hours for an expedited request. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Blue Care Network must revise its policies and procedures to include a provision in their policy and procedures to state approved tiering and non-formulary exception requests remain in effect the rest of the plan year. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.¿	Closed

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Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCN Advantage must conduct training of appropriate staff on the timely notification and effectuation of standard redeterminations concerning drug benefits. This should include situations where the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination. The Part D sponsor must effectuate and notify the enrollee in writing of its redetermination as expeditiously as the enrollee's health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination. BCN Advantage must submit documentation to the Chicago Regional Office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCN Advantage must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCN Advantage must conduct training of appropriate staff on the timely notification and effectuation of standard redeterminations concerning payment. This should include situations where the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination. The Part D sponsor must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. BCN Advantage must submit documentation to the Chicago Regional Office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCN Advantage must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

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Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Blue Care Network must revise its policies and procedures to state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Blue Care Network must revise its policies and procedures to state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA-PD	Audit Findings	7/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Blue Care Network must revise its policies and procedures regarding a third party reversal on an appeal for an expedited request for a benefit to state the Sponsor must take action as expeditiously as the enrollee's health requires but no later than 24 hours from the date it receives notice reversing the decision. Blue Care Network must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
PSO Health Services, LLC	1-210-949-4153	H4527	MA	Audit Findings	7/20/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	PSO Health Services must develop and implement procedures to ensure that the receipt date is maintained and can be verified for all reconsideration requests received by the organization. As the organization's policies and procedures currently include the requirement to date stamp incoming requests, the organization must take appropriate steps to ensure that actions to control incoming reconsideration requests are consistent with established internal policies and procedures. Further, the organization must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PSO Health Services should conduct an internal audit, on a monthly basis, of reconsideration requests received in order to evaluate documentation of the receipt date of the request. Your plan for corrective action should, at a minimum, provide for the submission of a quarterly summary report to the regional office of your monthly audit findings. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA	Audit Findings	7/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	1. CareOregon must revise its policies and procedures that instruct staff on the processing of Emergency and Urgent Care claims. The process must include a description of steps for development of these claims. 2. CareOregon must develop policies and procedures which describe the process for transferring claims between CareOregon and the delegate when necessary for processing. 3. CareOregon must conduct training of appropriate staff on these revised policies and procedures. Provide documentation to the RO that details the nature of the training, individual conducting the training, the materials used and the staff that attended. 4. CareOregon must establish a mechanism for ongoing monitoring of denied claims processed by the delegate. 5. CareOregon must conduct audits of denied claims and determine whether claim denials are correct, claims were developed appropriately, and plan processes were followed. 6. CareOregon must submit a summary report of its findings for itself and its delegated entity beginning with the first month after the CAP is accepted. The summary report should include title and name of the auditor(s), the audit methodology, and the results of the audit findings. CareOretgon must continue reporting this information to the RO for 3 consecutive months, or until compliance with CMS requirements is reached and sustained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA	Audit Findings	7/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	1. CareOregon must establish a mechanism for ongoing monitoring of claims timeliness for CareOregon and the delegate. 2. Provide the RO with a monthly report of claims timeliness for CareOregon and the delegate for non-contracted provider claims, beginning the first month after acceptance of the CAP. The report should be provided in the format currently used by the RO and include a summary of any issues which prevent CareOreogn from meeting the 95% standard. CareOregon must continue to report this information for 3 consecutive months, or until compliance with CMS requirements is reached and sustained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA	Audit Findings	7/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	1. CareOregon must revise its policies and procedures to reflect the correct method to calculate interest payment. 2. CareOregon must conduct training of appropriate staff on these revised policies and procedures. Provide documentation to the RO that details the nature of the training, individual conducting the training, the materials used, and the staff that attended. 3. CareOregon must establish a mechanism for ongoing monitoring of interest payment amounts. 4. CareOregon must submit monthly reports on this requirement beginning with the first month after acceptance of the CAP. CareOregon must continue reporting this information to the RO for 3 consecutive months or until compliance with CMS requirements is reached and sustained.	Closed

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CareOregon, Inc.	1-503-416-1421	H5859	MA	Audit Findings	7/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	1. CareOregon must develop denial messages for MA claims. 2. CareOregon must develop policies and procedures for use of the denial messages. This should include a description of the process for denied claims crossed over to secondary coverage under the Special Needs Plan. 3. CareOregon must conduct training of appropriate staff on these revised policies and procedures. Provide documentation to the RO that details the nature of the training, individual conducting the training, the materials used, and the staff that attended. 4. CareOregon must establish a mechanism for ongoing monitoring of denied claims processed by the delegate which reviews denial messages provided by the delegate. 5. CareOregon must submit a summary report of findings for the delegate beginning with the first month after the CAP is accepted. The summary report should include title and name of the auditor(s), the audit methodology, and the results of the audit findings. CareOregon must continue reporting this information to the RO for 3 consecutive months, or until compliance with CMS requirements is reached and sustained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA	Audit Findings	7/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	1. CareOregon must establish a mechanism for ongoing monitoring of pre-service organization determinations to ensure that requests are processed timely. 2. CareOregon must submit a summary report of its findings on the timeliness of organization determination processing beginning with the first month after CAP acceptance. The summary report should include title and name of the auditor(s), the audit methodology, and the results of the audit findings. CareOregon must continue reporting this information to the RO for 3 consecutive months, or until compliance with CMS requirements is reached and sustained.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA	Audit Findings	7/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	1. CareOregon must develop policies and procedures for use of the denial messages for pre-service denials. This should include a description of the process for denied services crossed over to secondary coverage under the Special Needs Plan. 2. CareOregon must conduct training of appropriate staff on these revised policies and procedures. Provide documentation to the RO that details the nature of the training, individual conducting the training, the materials used, and the staff that attended.	Closed
CareOregon, Inc.	1-503-416-1421	H5859	MA	Audit Findings	7/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Provide a representative universe for this element. If a universe is not available, provide an explanation to the reviewer.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Health Choice must revise its policies and procedures to include the requirements noted in the deficiency above. On 6/6/2007, Health Choice submitted a revised policy and procedure dated 5/29/2007 that meets this requirement. No further corrective action is required.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	(A) Health Choice must revise its policies and procedures to include the requirements discussed above. (B) Health Choice must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. (C) Health Choice must revise its contracts with marketing representatives to include the missing provisions and provide a plan to monitor this requirement to prevent deficiencies in the future.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	Health Choice must revise its policies and procedures to include the requirements discussed above. On 6/6/2007, the plan submitted a revised policy and procedure. However, this revision still does not include the requirement discussed above.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	(A) Health Choice must revise its policies and procedures to include the requirements discussed above. (B) Health Choice must advise CMS of the actions it is taking to ensure that it notifies the appropriate entities of required changes, including the responsible party or parties and means of communicating the changes. On 6/6/2007, Health Choice submitted a revised policy and procedure which mentions retrospective changes, but Health Choice must revise it further to include a description of the procedures for providing notice of the maintenance changes, other changes, and retrospective changes. The revision now mentions notification of CMS, SPAPs, and other entities providing other prescription drug coverage.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	(A) Health Choice must revise its policies and procedures, that of Express Scripts, to include the requirements discussed above and implement system reports as described above. (B) Health Choice must describe the actions it is taking to demonstrate that it has implemented LTC transition procedures. (C) Health Choice must also conduct training of appropriate staff on these policies and procedures and system reports and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Health Choice must revise its policy and procedures to include these provisions, which it did and submitted on 6/6/2007. The revised policy and procedure meets these requirements, therefore, no further corrective action is required.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	(A) Health Choice must revise its policy and procedures to include the provisions noted above. On 6/6/2007, the plan submitted revised policies and procedures which include provisions in (A)(1) and (3) above. However, the revised policies and procedures still need further revision to address the tracking of redeterminations. (B) Health Choice needs to modify the tracking log now used to include all of the required elements described above. (C) Health Choice must conduct training of appropriate staff on these policies and procedures and use of the tracking log, and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the a list of individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Health Choice must describe the steps it is taking to ensure that it notifies members of standard coverage determinations within the required timeframes. Corrective action must also include a description of Health Choice's plans for ongoing monitoring of its performance and training of appropriate staff on the process. For the later, submit documentation that details the nature of this training, including the materials used in the training, the individuals conducting the training, the names of individuals being trained and the date training is completed.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Health Choice must revise its policies and procedures to include the missing provisions. On 6/6/2007, Health Choice submitted a revised policy and procedure that meets these requirements. No further corrective action is required.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Health Choice must revise its policies and procedures to include the missing provisions noted above. On 6/6/2007, Health Choice submitted revised policies and procedures which included provisions for 1) and 2) above, but 3) and 4)above are still missing.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	(A) Health Choice must revise its policy and procedures to include the above noted provision. It submitted a revised policy and procedure on 6/6/2007 which meets this requirement. (B) Health Choice must describe the measures it is taking to ensure that members are notified appropriately within the required timeframes whenever Health Choice decides not to expedite an expedited coverage determination request.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	(A) Health Choice must revise its policy and procedures to include the provisions noted in (A) above. On 6/6/2007, the plan submitted a revised policy and procedure which meets this requirement and no further corrective action for the deficiency noted in (A) above is required. (B) Health Choice must submit for CMS approval a notice consistent with the CMS-issued model notice, Notice of Right to an Expedited Grievance. Refer to Appendix 3 of Chapter 18. (C) Health Choice must describe the actions it is taking to ensure ongoing compliance with the requirement to issue appropriate notice whenever it denys a request to expedite a coverage determination.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Health Choice must take the following action: (A) revise its policies and procedures to include the provisions noted above, (B) describe the actions it is taking to implement and monitor its ongoing performance to ensure that it makes decisions and notifies members within 24 hours of receiving expedited coverage determination requests (or for exceptions, receipt of supporting documentation), or, if unable to do so, forwards requests to the IRE within 24 hours of the adjudication timeframe. On 6/6/2007, Health Choice submitted a revised policy and procedure which meet requirements in (A) above. No further action is needed for (A) above.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Health Choice must take the following actions: (A) revise its policies and procedures to include the requirements discussed above, (B) describe the actions that it is taking to ensure that members receive appropriate notice (written and/or oral) of decisions, as well as its plans for ongoing monitoring of its performance to ensure continued compliance.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	((A) Health Choice must revise its policies and procedures to include the requirements noted in the deficiency above. (B) Health Choice must stop using the notice it submitted to CMS as audit documentation for this requirement and develop a new notice for requesting additional information for coverage exceptions from prescribing physicians. Refer to page 37 in Chapter 18 of the Prescription Drug Benefit Manual. The notice template in Appendix 11 of Chapter 18, although intended for members, may also be helpful in developing a notice for requesting information from prescribing physicians.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Health Choice must revise its policies and procedures to include the provisions noted in the deficiency above.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Health Choice must (A) revise its policies and procedures to include a description of the difference between a grievance and an inquiry, (B) advise CMS how it plans to communicate to members whether their complaints are subject to grievance or coverage determination procedures, (C) once Health Choice has made required revisions to its policy and procedures for this and all other grievance elements, conduct training for all staff involved in the grievance process in any way - from intake of complaints to final adjudication - to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Health Choice should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Health Choice must (A) revise its policies and procedures to include the requirements discussed above and (B) develop and implement a system for logging or capturing enrollees' grievances in a centralized location that will ensure their timely resolution. (C) conduct training of appropriate staff on these policies and procedures and the tracking system, and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	(A) Health Choice must revise its policy and procedures, which it did and submitted on 6/6/2007. The revised policy and procedure meets this requirement, therefore no further corrective action is required for (A). (B) Health Choice must conduct grievance training for its staff and its contractor(s), if involved.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	(A) Health Choice must revise its policies and procedures to include the provisions noted in the deficiency above. (B) Once Health Choice has made required revisions to its policy and procedures for this element and all other grievance elements, it must conduct training for all staff involved in the grievance process in any way from intake of complaints to final adjudication to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Health Choice should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	(A) Health Choice must revise its policies and procedures to remove the contradictory information and replace it with the correct information as noted in the deficiency above. (B) Once Health Choice has made required revisions to its policy and procedures for this element and all other grievance elements, it must conduct training for all staff involved in the grievance process in any way from intake of complaints to final adjudication to ensure that staff have a clear understanding of the entire grievance process and CMS requirements, as well as the details of their own respective roles in the process. Health Choice should submit copies of any training materials used (if applicable), and provide the name of the instructor, date(s) of training, and a list of staff attending.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	(A) Health Choice must revise its policy and procedures to include the provisions noted in (A) above. On 6/6/2007, the plan submitted a revised policy and procedures which meets the requirement for 1) above, but not 2). (B) Health Choice must revise the Pharmacy Tracking Log to include the missing items noted in (B) above.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	(A) Health Choice must revise its policies and procedures to include the requirements discussed above. (B) Health Choice must describe the actions it is taking to capture, track and process expedited Part D redetermination requests according to CMS requirements and submit documentation to support its plans. Corrective action should also include training for all staff involved in any way with identifying and processing expedited redetermination requests.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	(A) Health Choice must revise its policies and procedures to include the requirement noted in the deficiency above. (B) CMS will conduct a second focused audit of plan redeterminations 6 months after Health Choice has submitted acceptable revised policies and procedures for redeterminations and coverage determinations as part of its CAP, to ensure that the plan has appropriately implemented them.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	(A) Health Choice must revise its policies and procedures to include the requirement noted in the deficiency above. (B) Refer to CAR(B) for audit element RE03.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	(A) Health Choice must revise its policy and procedures to include the required provision discussed in (A) above. (B) Health Choice must 1) update the notice for informing enrollees of adverse standard redeterminations, and 2) establish a form/notice for requesting reconsiderations to be sent with adverse redetermination notices. Refer to Chapter 18, Appendix 4 and Appendix 13 respectively of the Prescription Drug Benefit Manual for model documents. Forms must be submitted through HPMS for approval or for acceptance, under file and use certification if adopted without changes. (C) Refer to CAR(B) for audit element RE03.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	(A) Health Choice must revise its policies and procedures to include the requirement discussed in (A)above. (B) Refer to the CAR for audit element RE05 (B) for notice deficiencies. (C) Refer to CAR (B) for audit element RE03.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	A) Health Choice must revise its policies and procedures to include the requirements discussed above. (B) Health Choice must establish a notice consistent with CMS-issued model notice, "Request for Reconsideration." Refer to the CAR for review element RE05. (C) Refer to CAR(B) for audit element RE03.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	(A) Health Choice must establish a system for authorizing or providing benefits under dispute within 72 hours of receiving requests for expedited redeterminations, when it reverses in whole or in part its prior coverage determinations. Corrective action must include a description of the system Health Choice implements, as well its plans for monitoring to ensure ongoing compliance. (B) Refer to CAR(B) for audit element RE03.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Refer to the CAR(B) for audit element RE03.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	(A) Health Choice must revise its policies and procedures to include the requirement discussed in (A) above. (B) Refer to CAR(B) for audit element RE03.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA-PD	Audit Findings	7/18/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	(A) Health Choice must revise its policies and procedures to include the requirement discussed above. (B) Health Choice must describe the plans it has to monitor its own performance to ensure that it meets this effectuation requirement on an continuing basis.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	Health Choice must develop and submit a report of aggregated appeal and grievance data for the latest report period and continuing that meets CMS guidelines in Chapter 13 of the Medicare Managed Care Manual, Sections 170-170.5.2.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Health Choice must describe the steps that it is taking to strengthen its oversight over the marketing activities of delegated contracted sales brokers and agents, should it decide to continue that relationship. It should also describe the actions it is taking to develop and implement an oversight program for its in-house direct contracted or employed sales force.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Health Choice must describe the actions it is taking to ensure that it provides written notice to Medicare members 30 days prior to PCP or other provider terminations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits to ensure compliance with CMS requirements.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	Health Choice must submit to CMS evidence that it has a Board of Directors that is accountable and responsible for the plan's QI Program. Health Choice must submit to CMS a copy of the 2007 QI Program that has been reviewed, approved and signed by the appropriate chairpersons, e.g., Board of Director's chairperson, QI Committee chairperson, along with the supporting Board of Director minutes reflecting review and approval of the QI program.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 05 - Quality Assurance	Significant Problems Corrected - The MAO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	Health Choice must develop a process (policy and procedure) to identify and correct quality of care issues that come to its attention through internal surveillance, complaints, or other mechanisms. The process must include internal plan audits to ensure compliance with CMS requirements.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Health Choice must describe the actions it is taking to ensure that it and its delegated entities credential/recredential contracted providers in accordance with CMS requirements, on a timely basis. Corrective action must include policy and procedure revisions for the health plan as well as its delegated entities. It must also include internal health plan audits as well as delegation oversight audits of credentialing files to ensure compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Health Choice must develop and implement a process to initially credential and recredential its contracted facilities. The process must include internal plan audits to assure compliance with CMS requirements.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Health Choice must describe the actions it is taking to ensure that the notices it sends members after investigating complaints, include descriptions of the disposition, as appropriate. Additionally, until further notice, Health Choice must send CMS (Regional Office, copies of all grievances it receives, along with copies of the letters it sends members notifying them of the grievance disposition. Copies of grievances and corresponding notices are due to CMS on the 15th of each month following the month in which they were closed.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Health Choice must describe the steps that it is taking to identify claims that may be related to an episode of emergent, urgent, post-stabilization or authorized care, and to ensure that it screens them against its claims data and if necessary, attempts development before denying them.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	(A) Health Choice must generate and submit a new universe that includes only non-contracted providers. Enclosure IV to the March 19, 2007 letter confirming the site visit includes details about what Health Choice should include in the universe for WSOC1 and the required format for submission. The review period for this universe is the original - September 1, 2006 through February 28, 2007. (B) Health Choice must revise its policy and procedure to incorporate the comments noted in the audit deficiency (B) above.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	(A) Refer to the corrective action required for element OC03. (B) Health Choice must revise its policy and procedure (M2.005.02) to reflect the provisions noted in the deficiency above.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Health Choice must start sending CMS compliant notices (the standardized Notice of Denial of Payment) to members when it denies claims from non-contracted providers. The description of denied services and the denial reasons used with the notice must be clear and understandable. As part of the required corrective action, Health Choice must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Health Choice must submit a new universe for WSOP1 (Standard Pre-Service Denials) for the review period September 1, 2006 through February 28, 2007. See Enclosure IV from the CMS letter to Health Choice dated March 19, 2007 for a description of the universe and the format for submission.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Health Choice must submit a new universe for WSOP1 (Standard Pre-Service Denials) for the review period September 1, 2006 through February 28, 2007. See Enclosure IV from the CMS letter to Health Choice dated March 19, 2007 for a description of the universe and the format for submission.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Health Choice must describe the actions it is taking to ensure that it is meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Health Choice must describe the actions it is taking to ensure that the NDMC contains denial reasons that are specific, clear and easily understood by the beneficiary in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Health Choice must describe the measures it is taking to ensure that it notifies members of favorable claim reconsideration decisions within CMS required timeframes. Corrective action should include provisions for internal monitoring to ensure ongoing compliance.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	Health Choice must submit a new universe for WSRC2 (unfavorable claims reconsiderations) but for an extended review period, 9/1/2006 through 6/30/2007, rather than the original review period. Refer to Enclosure IV of the 3/19/2007 letter from CMS confirming the site visit for details about the universe and submission format.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	Health Choice must generate a new universe for WSRP1 (favorable standard pre-service reconsiderations), but for an extended review period, 9/1/2007 through 6/30/2007, rather than the initial review period only. Refer to Enclosure IV for the 3/19/2007 letter from CMS confirming the site visit for details about the universe and submission format.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	Health Choice must describe the actions it is taking to ensure that it 1)forwards adverse standard pre-service reconsiderations to the IRE within the CMS required timeframe when it is unable to fully reverse its own decisions, and 2)notifies effected members concurrently that it is forwarding their cases to the IRE for a final reconsideration decision. Corrective action must include internal monitoring to ensure ongoing compliance.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Reconsideration Requests - The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.	Health Choice must revise its policy and procedure on appeals (M8.002.02) to include provisions for receiving, identifying, processing, and tracking expedited reconsideration requests.	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	Health Choice must describe the actions it is taking to ensure that it processes expedited reconsideration requests correctly within the required timeframes.	Closed
IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	(A) Health Choice must describe the actions it is taking to ensure that staff send the appropriate version of the "Notice of Right to an Expedited Grievance" when advising members that it will be processing their reconsiderations using standard rather than expedited appeal timeframes. (B) Health Choice must ensure that it has destroyed incorrect versions of the "Notice of Right to an Expedited Grievance."	Closed

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IASIS Healthcare	1-480-333-4528	H5587	MA	Audit Findings	7/18/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.	Health Choice must revise its policy and procedures to include the provisions noted in the deficiency above.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 06 - Provider Relations	Discrimination Against Health Care Professionals ProhibitedAn MAO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.	BCN Advantage should update its existing policy CR 3030 to incorporate the regulatory requirements at 42 CFR Part 422.205. Specifically, BCN Advantage should include the provision that an MA organization cannot discriminate in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her licensure or certification under State law, solely on the basis of the license or certification.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	BCN Advantage must conduct training of appropriate staff on the identification of grievances. Specifically, BCN Advantage should ensure that staff understand the proper distinction between grievances and appeals and the appropriate categorization of both. BCN Advantage should submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCN Advantage should conduct an internal audit of the grievances received each month. This audit should evaluate whether the grievances were appropriately catogorized and processed timely. BCN Advantage should submit a summary report once a quarter to the Regional Office of its monthly findings until further notice. In addition, BCN Advantage must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

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Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	BCN Advantage must conduct training of appropriate staff on the timely processing of grievances. BCN Advantage should submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, BCN Advantage must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	BCN Advantage must conduct training of appropriate staff on making correct claim determinations, which includes developing the claim for additional information when necessary for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services, and renal dialysis services that Medicare members obtain while temporarily out of the service area. BCN Advantage should submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCN Advantage must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	BCN Advantage must conduct training of appropriate staff on the payment of 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt. BCN Advantage should submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCN Advantage must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	BCN Advantage must conduct training of appropriate staff on the timely adjudication of non-clean claims, including the payment for, or denial of, all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt. BCN Advantage should submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCN Advantage must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

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Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	BCN Advantage must conduct training of appropriate staff on the handling of cases where BCN Advantage denies payment. This must include the provision of a written denial notice (CMS-10003-Notice of Denial of Payment (NDP), or an RO-approved modification of the NDP, to the member. The written denial must clearly state the service denied and the denial reason. BCN Advantage should submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCN Advantage must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	BCN Advantage must conduct training of appropriate staff on the handling of standard pre-service denials and submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, BCN Advantage must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	BCN Advantage must conduct training of appropriate staff on the timely processing of unfavorable standard pre-service reconsiderations and submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, BCN Advantage must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Blue Cross Blue Shield of Michigan	1-248-799-6437	H5883	MA	Audit Findings	7/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	BCN Advantage must conduct training of appropriate staff on the identification of and effectuation of third party standard pre-service reconsideration reversals and submit documentation to the Regional Office that details the nature of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, BCN Advantage must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

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Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	AAHP must revise its policies and procedures to include the provision noted above.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	AAHP must revise its policy and procedure to include the missing requirement noted above and submit a copy of the revised policy and procedure to CMS.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	AAHP must revise its policies and procedures to include the provision noted above and resubmit the revised version to CMS as part of its CAP.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	AAHP must develop a policy and procedure for contracting with LTC pharmacies that includes the missing provision noted in the finding above. Since its PBM, ESI, actually does the LTC contracting on the plan's behalf, AAHP must also ensure that its current PBM has policies and procedures that include this provision, and also describe how it is or will monitor ongoing compliance with the contracting requirement.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	AAHP must revise its polices and procedures to include the provisions noted above and submit them to CMS as part of its CAP.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	AAHP must either submit documentation showing the number and percentage of network pharmacies it has audited to ensure that pharmacies are posting or distributing notices describing how members may obtain coverage determinations or request exceptions, or it may develop a monitoring process and submit it along with a schedule.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	AAHP must correct its policies and procedures to include the above noted deficiencies. Refer to 42 CFR sections 423.566(b)(1-5) and 423.566 c) to obtain the information.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	(1) AAHP must revise its policies and procedures to incorporate the missing provisions noted above. Refer to Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, Section 130.2.3 and 42 CFR 423.568 (e). (2) AAHP must describe the measures it is taking to correct the processing deficiencies noted in (3) above to ensure timely payment decisions and member notification, and appropriate transfer of cases to the IRE if it does not make a determination within the prescribed time-frames. It should also describe how it will monitor performance to ensure compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	AAHP must either expand and update its current policy and procedure (desk procedure) or develop a comprehensive coverage determination policy and procedure that includes the above noted deficiencies. Refer to CFR 42 section 423.570 (c)(3) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, section 50.4.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	AAHP must either expand and update its current policy and procedure (desk procedure) or develop a comprehensive coverage determination policy and procedure that includes the above noted deficiencies. Refer to CFR 42 section 423.570 (d) and section 42.572(a) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, section 50.3.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	AAHP must either expand and update its current policy and procedure (desk procedure) or develop a comprehensive coverage determination policy and procedure that includes the above noted deficiencies. Refer to CFR 42 section 423.570 (d)(2) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, section 50.3.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AAHP must describe the measures it is taking to ensure that it makes expedited determinations and notifies members within required timeframes.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	AAHP Health Plan must update its policies and procedures to include the above noted deficiencies. Refer to 42 CFR sections 423.572 (b-c). AAHP must describe the steps it is taking to ensure compliance with notification requirements for expedited determinations, including ongoing monitoring for compliance.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	AAHP must either expand its current policy to include the provisions noted above in the finding, or develop a new comprehensive one for tiered cost-sharing exceptions. Refer to 42 CFR sections 423.578(a)(1-2), 423.578(a)(4) and Chapter 18 Part D Enrollee Grivances, Coverage Determinations, and Appeals, section 30.2.1. Additionally, AAHP needs to revise its member notice for missing information as indicated in the finding above. Refer to Appendix 11 in Chapter 18 of the Prescription Drug Manual.	Closed

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Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	AAHP must either expand its current policies and procedures to incorporate the above noted provisions or develop a comprehensive non-formulary drug exception policy and procedure. Refer to 42 CFR sections 423.578(b), 423.578(b)(2), 423.578(b)(5) and to Chapter 18 Enrollee Grivances, Coverage Determinations, and Appeals,section 30.2.2.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	AAHP must correct its internal coding to make sure that cases are correctly coded and resubmit a corrected universe WSGV1_D for the same review period, 9/1/06 through 2/28/07.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	AAHP must update its Policy and Procedures to correct the above noted deficiency. Refer to the Medicare Part D Reporting Requirements Contract Year 2007, section IV to obtain this information.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Refer to CAR for GV01_D.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Refer to CAR for GV01_D.	Closed

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Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	AAHP must either expand its current redetermination policy and procedure or develop a new comprehensive one that includes the above noted provisions. Refer to 42 CFR sections 423.582 (a-b) and 423.586.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	AAHP must either expand its current redetermination policy and procedure or develop a new comprehensive one that includes the above noted provisions. Refer to 42 CFR sections 423.584 (c)(1) and 423.586.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	AAHP must either expand its current redetermine policy and procedure or develop a new comprehensive one that includes the above noted provisions. Refer to 42 CFR section 423.584 (c)(2).	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	AAHP must either expand its current policy and procedure or develop a new comprehensive one that includes the provisions noted above. Refer to 42 CFR section 423.584(d)(2).	Closed

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Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AAHP must either expand its current policy and procedure or develop a new comprehensive one covering redeterminations that include the above-noted provision. Refer to Chapter 18, Part D Enrollee and Grievances, Coverage Determinations, and Appeals, section 70.10.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AAHP must either expand it current policy and procedure or develop a new comprehensive one for redeterminations that includes the above noted provisions. Refer to 42 CFR section 423.590 (b) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations and Appeals, section 70.10.	Closed

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Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AAHP must either expand its current policy to include the provisions cited in the finding above, or develop a new comprehensive redetermination policy and procedure. Refer to 42 CFR sections 423.590 (d-e) and Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, section 70.10.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	AAHP must (1) either revise its current policy or develop a new comprehensive redetermination policy and procedure that includes the above noted provisions. It must submit the revised/new policy and procedure to CMS with its CAP. Refer to 42 CFR section 423.638 (a). (2) describe in its CAP the steps that it is taking to ensure ongoing compliance with the requirements in this element.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA-PD	Audit Findings	6/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	AAHP must either expand its current policy and procedure to incude the above-noted provisions or develop a new comprehensive policy and procedure for redeterminations. It must submit the revised/new policy and procedure to CMS with its CAP. Refer to Chapter 18 Part D Enrollee Grievances, Coverage Determinations and Appeals, section 70.20.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	AAHP must develop and submit as part of its CAP, materials that meet the disclosure requirements noted above.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	AAHP must determine and report to CMS why it was unable to produce an accurate universe for WSGV1 and describe the steps it is taking, including any changes to its coding or tracking system, to ensure that it's system can distinguish Part C grievances from Part D grievances for reporting and other purposes. It must also produce and submit to CMS a new universe for WSGV1. The review period for the universe is the orginal one, 9/1/07 through 2/28/07.	Closed

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Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Refer to the CAR for review element GV01.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Refer to the CAR for element GV01.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	Refer to CAR for review element GV01.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	AAHP must make the requested revisions to the EOB (H5986_077)and resubmit it for approval. It must also describe the measures it is taking to improve the EOB descriptions of services, and specificity of denial reasons.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The health plan identified and corrected this deficiency prior to the CMS audit. A written corrective action for expedited organization determinations dated 3/07 was submitted by Abrazo Advantage Health Plan and accepted by CMS during the onsite CMS audit.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	AAHP must generate a new universe for WSRP1 and submit it to CMS for further action. Since there are potentially so few cases in the original universe to consider, the review period for the new universe is being changed to 12/1/06 through 05/30/07 for this sample.	Closed
Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	AAHP must determine the reason(s) it was late forwarding cases to the IRE when it did not make a fully favorable decisions within the required 30 day time-frame. Its corrective action plan must describe the reason(s)cases were late and the actions it is taking to ensure ongoing compliance.	Closed

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Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	AAHP must revise its desk procedure, Part C - Effectuation of Member Appeals/Reconsiderations to incorporate the details noted as deficient in the finding above and resubmit it as part of its CAP. It must also conduct training on appeal processing for all staff involved in any way with Part C appeals covering both expedited and standard preservice appeals, as well as payment appeals from members, authorized representatives, and in the case of payment appeals, from non-contracting providers that provided services in question. Advise CMS of the date training is completed with documentation of those who attended.	Closed

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Vanguard Health Systems	1-602-824-3733	H5985	MA	Audit Findings	6/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.	AAHP must revise its procedure (Part C-Effectuation of Member Appeals/Reconsiderations) to address the deficiencies noted above and submit the revised version to CMS as part of the CAP. Additionally, it must provide training on the revised procedure to any staff involved in any way with the appeals process and submit the date of actual/scheduled training, and when completed, the roster of those who attended.	Closed

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CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	1.CalOptima must develop and implement a policy and procedure (P and P) that defines the oversight and monitoring process of sales and marketing activities of sales reps. The P and P should address how sales reps will be trained, both initially and on an ongoing basis, how their sales activities will be monitored, by whom, and at what frequency, what performance data will be collected, by whom, how frequently, and how that data will be used and communicated to the sales rep, and what actions will be implemented for perceived sales and marketing abuses. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. 2.Indicate in the P and P for overseeing sales reps who is responsible for those oversight activities. 3.Include in the P and P for overseeing sales reps that they must provide the required written disclosure to members. 4.Develop and implement a P and P that ensures sales reps are providing potential enrollees with the required written disclosure statement. 5.Develop a contract with a compensation structure for all sales reps that indicates the following: ¿A contractual relationship exists between the Medicare Advantage plan and the sales rep. ¿That the compensation is in line with industry standards. ¿That the incentive structure is in compliance with CMS requirements. ¿That sales reps are prohibited from offering payment as a condition of enrollment. ¿That there is a provision for withholding pay for rapid disenrollment (i.e., chargebacks). ¿That there is a provision for the required written disclosure statement to be provided to potential enrollees. 6.Develop a process to ensure that sales reps files contain documentation of all training, oversight, and monitoring activities. 7.Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	CalOptima must develop a process to ensure that EOBs clearly indicate the effective date of the formulary change. Also, an alternate process must be developed to inform members of a formulary change when no EOB will be sent to such members in a given month because they have not received prescription drugs that month. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Submit documentation that demonstrates that network pharmacies are responsible for posting or distributing notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist. Also provide evidence that network pharmacies are aware of this requirement. Finally, revise the contract with your pharmacy audit contractor to ensure this provision is included in the audit protocol.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Develop policies and procedures that track requests, both oral and written, for Part D coverage determinations. The process should track, at a minimum, the date of receipt, the date of notification, the disposition of the request, and the date the disposition was made. Conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Modify your Part D coverage determination process to include: ¿ documentation of the date and time the member was verbally notified of a favorable decision. ¿ documentation of the date and time of verbal and written notification of an adverse decision. ¿ a process for forwarding the case to the Independent Review Entity within 24 hours after the expiration of the adjudication timeframe, when the health plan fails to provide notification within 72 hours of receipt of the request. Conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	CalOptima must revise its policies and procedures to include provisions stating: ¿that the health plan must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician¿s supporting statement. ¿that the health plan must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician¿s supporting statement. ¿that failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the health plan to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. Conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	CalOptima must notify enrollees of an adverse coverage determination decision using a CMS-approved notice, and provide documentation of this to CMS.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Revise MA.6101 to include a phone and fax number for submission of expedited coverage determination requests.	Closed

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CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	Submit for review a notice that notifies the enrollee that a request for an expedited coverage determination is denied. It should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Revise MA.6101 to include the following: ¿ a process to ensure that the date and time the member is notified of your decision is documented. ¿ a process to ensure that a decision is made and communicated to the member within 24 hours of receipt of the member¿s request. ¿ a process to ensure that if the decision is adverse and the member is notified orally within 24 hours of receipt of the request, the oral notification is followed by a written notification to the member within 3 calendar days of the oral notification. ¿ a process to ensure that if no decision is made and communicated to the member within 24 hours of receipt of their request, the request is forwarded to the IRE within 24 hours of the expiration of the adjudication timeframe (i.e., within 48 hours of receipt of the request). ¿ a process to ensure that if the case is forwarded to the IRE, the member is notified of this action within 24 hours of the expiration of the adjudication timeframe (i.e., within 48 hours of receipt of the request). Also, conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	CalOptima must develop and implement policies and procedures that include the provisions described above. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained. CalOptima must develop a notice consistent with the CMS-issued standard notice, Request for Additional Information. It should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed

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CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	CalOptima must develop and implement policies and procedures that include the provisions described above. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	CalOptima must revise its policies and procedures and its template grievance notice to inform members of which category¿grievance or coverage determination¿their complaint falls into. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Revise P and P MA.6102 to include the missing requirements described in the finding for GV02. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.		Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.		Closed

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CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	CalOptima must revise its policies and procedures to include the provisions described above. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CalOptima must revise its policies and procedures to include a process for the health plan to inform the enrollee within 24 hours that their reconsideration request has been forwarded to the IRE. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained. CalOptima must develop a notice consistent with the CMS-issued standard notice, Request for Reconsideration. It should be submitted in HPMS for regional office review. Please also include a copy of the notice with your Corrective Action Plan (CAP).	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CalOptima must revise its policies and procedures to address the deficiencies described above. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	CalOptima must revise its policies and procedures to address the deficiencies described above, both those discovered through the sample case review as well as review of the policies and procedures. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	CalOptima must develop a process to ensure that when it reverses, in whole or in part, its coverage determination based on an expedited request for Part D benefits, it authorizes or provides the benefit as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date it receives the enrollee¿s request.	Closed

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CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	CalOptima must revise its policies and procedures to state that case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
CalOptima	1-714-246-8638	H5433	MA-PD	Audit Findings	6/21/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	CalOptima must revise its policies and procedures to require that an actual notice is sent to the IRE informing them of the effectuation of the IRE¿s decision. CalOptima must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Contra Costa Health Services	1-925-313-6000	H0502	MA	Audit Findings	6/5/2007	Closed	Chapter 03 - Marketing	The Cost plan makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP at least 30 days prior to such termination. The Cost plan makes a good faith effort to provide written notice of the termination of any contracted provider to all members regularly seen by that provider at least 30 calendar days before such termination.	Describe actions Contra Costa Health Plan is taking to assure meeting the written notice to Medicare members 30 days prior to the termination of his/her PCP in accordance with CMS policy and regulations.	Closed
Contra Costa Health Services	1-925-313-6000	H0502	MA	Audit Findings	6/5/2007	Closed	Organization Determinations, Grievances, and Appeals - Organization Determinations - Claims		Contra Costa must submit an explanation of the process used to pay its contracted physicians at CCRMC to ensure duplicate payment is not made by Original Medicare and the health plan.	Closed
Contra Costa Health Services	1-925-313-6000	H0502	MA	Audit Findings	6/5/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Contra Costa Health Plan must ensure it identifies and processes appeals and grievances appropriately.	Closed
Contra Costa Health Services	1-925-313-6000	H0502	MA	Audit Findings	6/5/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Contra Costa must update their policy and procedures to ensure interest is paid for clean non-contracting provider claims paid after 30 days of receipt. In addition, it appears the interest payment is a manual process, therefore, we require Contra Costa to conduct training to staff on its policy and procedure and to inform us of the date the training is completed.	Closed
Contra Costa Health Services	1-925-313-6000	H0502	MA	Audit Findings	6/5/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Contra Costa Health Plan must revise the Notice of Payment Denial to exclude additional language not found on the CMS standard notice. September 2005, CMS Regional Office received clarification from Central Office that the standardized notice must not be changed from the model except in limited circumstances. As a result of this clarification, we are requiring the health plan to revise this notice and if Medi-Cal appeal rights apply for a denied service, Contra Costa must issue a separate notice.	Closed
Contra Costa Health Services	1-925-313-6000	H0502	MA	Audit Findings	6/5/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	Develop and submit Contra Costa Health Plan's policy and procedure for identifying Medicare Secondary Payer situations when Senior Health Plan members obtain medical services from contracted providers.	Closed

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Contra Costa Health Services	1-925-313-6000	H0502	MA	Audit Findings	6/5/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Describe the actions Contra Costa Health Plan is taking to assure that it issues the CMS required NDMC.	Closed
Hawaii Medical Service Association	1-808-948-6584	H1251	MA	Audit Findings	6/5/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions HMSA is taking to assure meeting the 14 calendar day processing of standard organization determinations in accordance with CMS policy and regulations. Include in the process how HMSA will assure that extensions to the decision-making process (standard and expedited organization determinations) are only implemented if the Medicare member requests the extension or if the health plan justifies the need for additional information and explains how the delay is in the best interest of the member.	Closed
Hawaii Medical Service Association	1-808-948-6584	H1251	MA	Audit Findings	6/5/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Describe actions HMSA is taking to assure meeting the 72 hours processing of expedited organization determinations in accordance with CMS policy and regulations.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	Arcadian must develop and provide documentation to CMS that the above mentioned items will be available to beneficiaries upon request.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Arcadian must review its welcome call policy and scripts to ensure it complies with CMS requirements and that this policy is implemented in all market areas. A copy of the welcome call policy must be submitted to our office for review. Also, forward a copy of any follow up activity to the internal audit for this element, including ongoing monitoring reports for each market area to ensure compliance with this element.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Arcadian must ensure its marketing representatives and brokers receive the same level of training on the MA product. Arcadian must also ensure marketing oversight is consistent between its marketing representatives and brokers, and that all files are updated accordingly. In addition, we also recommend Arcadian develop a more formal process to effectively train and to monitor marketing representative and broker performance for all market areas especially where rapid disenrollment statistics are higher than Plan standards. This process may include: - All marketing representatives and brokers and agents to sign a MA Sales Code of Coduct on an annual basis. This document would clearly state code of conduct violations regarding enrollment applications, HIPAA Guidelines, Events and Giveaways, Prohibited Solicitation, and other applicable information from Chapter 2 Enrollment and Chapter 3 Marketing Guides. - All sales representatives and brokers/agents receive compliance training on Medicare Part D Fraud, Waste and Abuse at time of employment and annually thereafter. A signed compliance statement of attestation and certification after completion of the training should be included in all sales personnel files. - All sales representatives sign a Medicare Prescription Drug Plan Marketing Compliance Requirement document that clearly states critical information that the sales representative agrees to comply with for Medicare Part D sales, along with the CMS Marketing Guidelines. - A database to monitor performance and identify issues and areas where additional training updates can improve overall performance. A database should be developed for all sales personnel that will allow Arcadian to profile by market area, issue, sales representative, broker or agent, and by overall volume of complaints. The corrective action plan must describe the types of oversight activities and process improvements Arcadian will implement to effectively monitor the sales operations. Also include a schedule of training and submit a copy of traning materials that will be used.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Describe actions Arcadian Health Plan is taking to assure meeting the written notice to Medicare members 30 days prior to the termination of his/her PCP in accordance with CMS policy and regulations. The process must include internal audits to assure compliance with CMS requirements.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Access to Care - The MAO has written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS, continuously monitors its provider networks' compliance with these standards, and takes corrective action as necessary. The MAO ensures that the hours of operation of its providers are convenient to and do not discriminate against members. When medically necessary, the MAO makes services available 24 hours a day, 7 days a week.	Submit to CMS all access and availability audits conducted on the plan's contracted network since the initiation of the CMS contract 1/1/05 and evidence that these audits were reported to the QI committee.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	Submit to CMS a signed copy of 2006 QI Program and minutes from the executive board demonstrating that the QI program was reviewed and approved by the policy oversight body, executive board. Submit to CMS a revised QI committee reporting structure integrating information from claims, provider relations, member services/enrollment and marketing/sales information into the QI committee.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	Submit to CMS a signed copy of 2006 UM Program and minutes from the executive board that the UM program was reviewed and approved by the policy oversight body, executive board.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	Submit to CMS evidence of pre-delegation credentialing audits for all Arcadian Health Plan contracted delegated credentialing entities.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Describe the actions Arcadian Health Plan is taking to assure it initially credentials and recredentials its contracted providers in accordance with CMS requirements. The corrective action must include regular internal auditing of credentialing files to assure compliance. Arcadian Health Plan must immediately develop, implement and submit to CMS a credentialing oversight process to assure groups delegated responsibility for credentialing meet CMS requirements. This oversight process must include regular audits of credentialing files and include a corrective action process for any deficiencies found. Submit to CMS the initial pre delegation audits for each delegated credentialing entity.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 06 - Provider Relations	Process for Consultation with Health Care Professionals Regarding CredentialingThe MAO must have a process for health care professionals' input in the credentialing process.	Submit to CMS a detailed description of Arcadian Health Plans credentialing process including the delegated credentialing for the plans contracted network. Identify where and when peer review occurs and how it is integrated into the AHP credentialing/recredentialing process.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Arcadian Health Plan, Inc. (Arcadian) must establish and maintain effective oversight and control of grievance and reconsideration operations to ensure Arcadian staff identify and process grievances and reconsiderations, timely and appropriately. The corrective action plan (CAP) must describe the types of oversight activities Arcadian will implement. The CAP should, at a minimum, include the following: -Arcadian must develop and implement a policy and procedure to effectively monitor the receipt and processing of standard and expedited grievances and reconsiderations. --Arcadian must conduct training to staff on its policies and procedures to ensure grievances and reconsiderations are identified and processed timely and appropriately. Submit documentation to the Regional Office that details the nature of the training, including (1) the date(s) of the training, (2) materials used in the training, (3) the individuals conducting the training, and (4) individuals being trained. -Arcadian must be able to produce valid universe listings for grievances and reconsiderations so that CMS can select another review sample for a focused review to occur later during the year. --Arcadian must conduct an audit each month to evaluate accurate selection of the grievance and reconsideration universes and to ensure compliance with CMS grievance and reconsideration monitoring elements. Arcadian should submit a summary report each quarter to the CMS Regional Office, of monthly audit findings, until further notified by CMS. The summary report should include: name and title of the auditor(s), the audit methodology and the audit findings. If problem areas are identified, please provide CMS with a copy of the CAP implemented by Arcadian in order to resolve the problem(s).	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	See Corrective Action Required for element GV01.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	See Corrective Action Required in element GV01.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	See Corrective Action Required in GV01.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Arcadian must establish and maintain effective oversight and control over its claims processing operations to ensure processors develop and deny non-contracting provider claims appropriately and propose a corrective action plan that describes the types of oversight activities it will implement. The CAP should at a minimum include the following: -Arcadian must conduct training to staff on its policies and procedures to ensure non-contracted provider claims are adjudicated appropriately by Arcadian or its Subcontracted Entity - Vision Service Provider (VSP). -Submit documentation to the Regional Office that details the nature of the training, including (1) the date(s) of the training, (2) materials used in the training, (3) the individuals conducting the training, and (4) individuals being trained. -Arcadian must conduct an audit each month to evaluate the selection of the denied claims universe, development and adjudication of non-contracted provider claims, and notification to the member of the denials. Arcadian should submit a summary report each quarter to the Regional Office of its monthly findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, and the results of the audit. If deficiencies are identified, please provide us with a copy of the corrective action plan to resolve the problem. On July 31, 2006, Arcadian issued an educational bulletin to staff reminding them of the correct procedure for "Handling Unclean Claims" (OPS-030)from non-contracted providers before denying the claim for no prior authorization. OPS-030 must be revised to ensure all unclean claims are either paid or denied within 60 days of receipt. If additional information is requested and not received, Arcadian must make a payment or denial determination based on the available information rather than closing the claim until the documentation is received. Claims development procedures should also include contacting the contracted primary care physician or specialist to determine if the member was referred to the non-contracted provider when necessary.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Arcadian must analyze the interest payment process to determine the cause of the interest calculation error. Submit to CMS your analysis, corrective action, and the estimated date of completion.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Arcadian must ensure all members receive a written denial notice for non-contracted provider claim denials. Refer to Corrective Action Required in Element OC01 for staff training, claims operations oversight and reporting requirements.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	Arcadian must revise the policy and procedures to identify payers that are primary to Medicare, identify the amounts payable by those payers, and coordinate its benefits to Medicare enrollees with the benefits of the primary payers. Additional information is available in the Medicare Managed Care Manual, Chapter 4 Benefits and Beneficiary Protection, Section 80 Medicare Secondary Payer Procedures.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions Arcadian Health Plan is taking to assure meeting the 14 calendar day processing of standard organization determinations in accordance with CMS policy and regulations.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Describe the actions Arcadian Health Plan is taking to assure that it issues the CMS required NDMC.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Describe actions Arcadian Health Plan is taking to assure meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Arcadian Management Services Inc.	1-510-817-1036	H0320	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Arcadian Health Plan, Inc. (Arcadian) must establish and maintain effective oversight and control of reconsideration operations to ensure Arcadian staff receive and process appeals, timely and appropriately. The corrective action plan (CAP) must describe the types of oversight activities Arcadian will implement. The CAP should, at a minimum, include the following: -Arcadian must develop and implement a policy and procedure to effectively monitor the receipt and processing of standard and expedited reconsiderations. -Arcadian must be able to produce a valid reconsideration universe so that CMS can select another review sample for a focused review that will be scheduled at a later date. --Arcadian must conduct an audit each month to evaluate accurate selection of the reconsideration universes and to ensure compliance with CMS reconsideration monitoring elements. Arcadian should submit a summary report each quarter to the CMS Regional Office, of monthly audit findings, until further notified by CMS. The summary report should include: name and title of the auditor(s), the audit methodology and the audit findings. If problem areas are identified, please provide CMS with a copy of the CAP implemented by Arcadian in order to resolve the problem(s).	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	Arcadian must develop and provide documentation to CMS that the above mentioned items will be available to beneficiaries upon request.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Arcadian must review its welcome call policy and scripts to ensure it complies with CMS requirements and that this policy is implemented in all market areas. A copy of the welcome call policy must be submitted to our office for review. Also, forward a copy of any follow up activity to the internal audit for this element, including ongoing monitoring reports for each market area to ensure compliance with this element.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Arcadian must ensure its marketing representatives and brokers receive the same level of training on the MA product. Arcadian must also ensure marketing oversight is consistent between its marketing representatives and brokers, and that all files are updated accordingly. In addition, we also recommend Arcadian develop a more formal process to effectively train and to monitor marketing representative and broker performance for all market areas especially where rapid disenrollment statistics are higher than Plan standards. This process may include: - All marketing representatives and brokers and agents to sign a MA Sales Code of Coduct on an annual basis. This document would clearly state code of conduct violations regarding enrollment applications, HIPAA Guidelines, Events and Giveaways, Prohibited Solicitation, and other applicable information from Chapter 2 Enrollment and Chapter 3 Marketing Guides. - All sales representatives and brokers/agents receive compliance training on Medicare Part D Fraud, Waste and Abuse at time of employment and annually thereafter. A signed compliance statement of attestation and certification after completion of the training should be included in all sales personnel files. - All sales representatives sign a Medicare Prescription Drug Plan Marketing Compliance Requirement document that clearly states critical information that the sales representative agrees to comply with for Medicare Part D sales, along with the CMS Marketing Guidelines. - A database to monitor performance and identify issues and areas where additional training updates can improve overall performance. A database should be developed for all sales personnel that will allow Arcadian to profile by market area, issue, sales representative, broker or agent, and by overall volume of complaints. The corrective action plan must describe the types of oversight activities and process improvements Arcadian will implement to effectively monitor the sales operations. Also include a schedule of training and submit a copy of traning materials that will be used.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Describe actions Arcadian Health Plan is taking to assure meeting the written notice to Medicare members 30 days prior to the termination of his/her PCP in accordance with CMS policy and regulations. The process must include internal audits to assure compliance with CMS requirements.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Access to Care - The MAO has written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS, continuously monitors its provider networks' compliance with these standards, and takes corrective action as necessary. The MAO ensures that the hours of operation of its providers are convenient to and do not discriminate against members. When medically necessary, the MAO makes services available 24 hours a day, 7 days a week.	Submit to CMS all access and availability audits conducted on the plan's contracted network since the initiation of the CMS contract 1/1/05 and evidence that these audits were reported to the QI committee.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	Submit to CMS a signed copy of 2006 QI Program and minutes from the executive board demonstrating that the QI program was reviewed and approved by the policy oversight body, executive board. Submit to CMS a revised QI committee reporting structure integrating information from claims, provider relations, member services/enrollment and marketing/sales information into the QI committee.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	Submit to CMS a signed copy of 2006 UM Program and minutes from the executive board that the UM program was reviewed and approved by the policy oversight body, executive board.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	Submit to CMS evidence of pre-delegation credentialing audits for all Arcadian Health Plan contracted delegated credentialing entities.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Describe the actions Arcadian Health Plan is taking to assure it initially credentials and recredentials its contracted providers in accordance with CMS requirements. The corrective action must include regular internal auditing of credentialing files to assure compliance. Arcadian Health Plan must immediately develop, implement and submit to CMS a credentialing oversight process to assure groups delegated responsibility for credentialing meet CMS requirements. This oversight process must include regular audits of credentialing files and include a corrective action process for any deficiencies found. Submit to CMS the initial pre delegation audits for each delegated credentialing entity.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 06 - Provider Relations	Process for Consultation with Health Care Professionals Regarding CredentialingThe MAO must have a process for health care professionals' input in the credentialing process.	Submit to CMS a detailed description of Arcadian Health Plans credentialing process including the delegated credentialing for the plans contracted network. Identify where and when peer review occurs and how it is integrated into the AHP credentialing/recredentialing process.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Arcadian Health Plan, Inc. (Arcadian) must establish and maintain effective oversight and control of grievance and reconsideration operations to ensure Arcadian staff identify and process grievances and reconsiderations, timely and appropriately. The corrective action plan (CAP) must describe the types of oversight activities Arcadian will implement. The CAP should, at a minimum, include the following: -Arcadian must develop and implement a policy and procedure to effectively monitor the receipt and processing of standard and expedited grievances and reconsiderations. --Arcadian must conduct training to staff on its policies and procedures to ensure grievances and reconsiderations are identified and processed timely and appropriately. Submit documentation to the Regional Office that details the nature of the training, including (1) the date(s) of the training, (2) materials used in the training, (3) the individuals conducting the training, and (4) individuals being trained. -Arcadian must be able to produce valid universe listings for grievances and reconsiderations so that CMS can select another review sample for a focused review to occur later during the year. --Arcadian must conduct an audit each month to evaluate accurate selection of the grievance and reconsideration universes and to ensure compliance with CMS grievance and reconsideration monitoring elements. Arcadian should submit a summary report each quarter to the CMS Regional Office, of monthly audit findings, until further notified by CMS. The summary report should include: name and title of the auditor(s), the audit methodology and the audit findings. If problem areas are identified, please provide CMS with a copy of the CAP implemented by Arcadian in order to resolve the problem(s).	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	See Corrective Action Required for element GV01.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	See Corrective Action Required in element GV01.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	See Corrective Action Required in GV01.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Arcadian must establish and maintain effective oversight and control over its claims processing operations to ensure processors develop and deny non-contracting provider claims appropriately and propose a corrective action plan that describes the types of oversight activities it will implement. The CAP should at a minimum include the following: -Arcadian must conduct training to staff on its policies and procedures to ensure non-contracted provider claims are adjudicated appropriately by Arcadian or its Subcontracted Entity - Vision Service Provider (VSP). -Submit documentation to the Regional Office that details the nature of the training, including (1) the date(s) of the training, (2) materials used in the training, (3) the individuals conducting the training, and (4) individuals being trained. -Arcadian must conduct an audit each month to evaluate the selection of the denied claims universe, development and adjudication of non-contracted provider claims, and notification to the member of the denials. Arcadian should submit a summary report each quarter to the Regional Office of its monthly findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, and the results of the audit. If deficiencies are identified, please provide us with a copy of the corrective action plan to resolve the problem. On July 31, 2006, Arcadian issued an educational bulletin to staff reminding them of the correct procedure for "Handling Unclean Claims" (OPS-030)from non-contracted providers before denying the claim for no prior authorization. OPS-030 must be revised to ensure all unclean claims are either paid or denied within 60 days of receipt. If additional information is requested and not received, Arcadian must make a payment or denial determination based on the available information rather than closing the claim until the documentation is received. Claims development procedures should also include contacting the contracted primary care physician or specialist to determine if the member was referred to the non-contracted provider when necessary.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Arcadian must analyze the interest payment process to determine the cause of the interest calculation error. Submit to CMS your analysis, corrective action, and the estimated date of completion.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Arcadian must ensure all members receive a written denial notice for non-contracted provider claim denials. Refer to Corrective Action Required in Element OC01 for staff training, claims operations oversight and reporting requirements.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	Arcadian must revise the policy and procedures to identify payers that are primary to Medicare, identify the amounts payable by those payers, and coordinate its benefits to Medicare enrollees with the benefits of the primary payers. Additional information is available in the Medicare Managed Care Manual, Chapter 4 Benefits and Beneficiary Protection, Section 80 Medicare Secondary Payer Procedures.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions Arcadian Health Plan is taking to assure meeting the 14 calendar day processing of standard organization determinations in accordance with CMS policy and regulations.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Describe the actions Arcadian Health Plan is taking to assure that it issues the CMS required NDMC.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Describe actions Arcadian Health Plan is taking to assure meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Arcadian Management Services Inc.	1-510-817-1036	H4529	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Arcadian Health Plan, Inc. (Arcadian) must establish and maintain effective oversight and control of reconsideration operations to ensure Arcadian staff receive and process appeals, timely and appropriately. The corrective action plan (CAP) must describe the types of oversight activities Arcadian will implement. The CAP should, at a minimum, include the following: -Arcadian must develop and implement a policy and procedure to effectively monitor the receipt and processing of standard and expedited reconsiderations. -Arcadian must be able to produce a valid reconsideration universe so that CMS can select another review sample for a focused review that will be scheduled at a later date. --Arcadian must conduct an audit each month to evaluate accurate selection of the reconsideration universes and to ensure compliance with CMS reconsideration monitoring elements. Arcadian should submit a summary report each quarter to the CMS Regional Office, of monthly audit findings, until further notified by CMS. The summary report should include: name and title of the auditor(s), the audit methodology and the audit findings. If problem areas are identified, please provide CMS with a copy of the CAP implemented by Arcadian in order to resolve the problem(s).	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	Arcadian must develop and provide documentation to CMS that the above mentioned items will be available to beneficiaries upon request.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Arcadian must review its welcome call policy and scripts to ensure it complies with CMS requirements and that this policy is implemented in all market areas. A copy of the welcome call policy must be submitted to our office for review. Also, forward a copy of any follow up activity to the internal audit for this element, including ongoing monitoring reports for each market area to ensure compliance with this element.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Arcadian must ensure its marketing representatives and brokers receive the same level of training on the MA product. Arcadian must also ensure marketing oversight is consistent between its marketing representatives and brokers, and that all files are updated accordingly. In addition, we also recommend Arcadian develop a more formal process to effectively train and to monitor marketing representative and broker performance for all market areas especially where rapid disenrollment statistics are higher than Plan standards. This process may include: - All marketing representatives and brokers and agents to sign a MA Sales Code of Coduct on an annual basis. This document would clearly state code of conduct violations regarding enrollment applications, HIPAA Guidelines, Events and Giveaways, Prohibited Solicitation, and other applicable information from Chapter 2 Enrollment and Chapter 3 Marketing Guides. - All sales representatives and brokers/agents receive compliance training on Medicare Part D Fraud, Waste and Abuse at time of employment and annually thereafter. A signed compliance statement of attestation and certification after completion of the training should be included in all sales personnel files. - All sales representatives sign a Medicare Prescription Drug Plan Marketing Compliance Requirement document that clearly states critical information that the sales representative agrees to comply with for Medicare Part D sales, along with the CMS Marketing Guidelines. - A database to monitor performance and identify issues and areas where additional training updates can improve overall performance. A database should be developed for all sales personnel that will allow Arcadian to profile by market area, issue, sales representative, broker or agent, and by overall volume of complaints. The corrective action plan must describe the types of oversight activities and process improvements Arcadian will implement to effectively monitor the sales operations. Also include a schedule of training and submit a copy of traning materials that will be used.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Describe actions Arcadian Health Plan is taking to assure meeting the written notice to Medicare members 30 days prior to the termination of his/her PCP in accordance with CMS policy and regulations. The process must include internal audits to assure compliance with CMS requirements.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Access to Care - The MAO has written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS, continuously monitors its provider networks' compliance with these standards, and takes corrective action as necessary. The MAO ensures that the hours of operation of its providers are convenient to and do not discriminate against members. When medically necessary, the MAO makes services available 24 hours a day, 7 days a week.	Submit to CMS all access and availability audits conducted on the plan's contracted network since the initiation of the CMS contract 1/1/05 and evidence that these audits were reported to the QI committee.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	Submit to CMS a signed copy of 2006 QI Program and minutes from the executive board demonstrating that the QI program was reviewed and approved by the policy oversight body, executive board. Submit to CMS a revised QI committee reporting structure integrating information from claims, provider relations, member services/enrollment and marketing/sales information into the QI committee.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	Submit to CMS a signed copy of 2006 UM Program and minutes from the executive board that the UM program was reviewed and approved by the policy oversight body, executive board.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	Submit to CMS evidence of pre-delegation credentialing audits for all Arcadian Health Plan contracted delegated credentialing entities.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Describe the actions Arcadian Health Plan is taking to assure it initially credentials and recredentials its contracted providers in accordance with CMS requirements. The corrective action must include regular internal auditing of credentialing files to assure compliance. Arcadian Health Plan must immediately develop, implement and submit to CMS a credentialing oversight process to assure groups delegated responsibility for credentialing meet CMS requirements. This oversight process must include regular audits of credentialing files and include a corrective action process for any deficiencies found. Submit to CMS the initial pre delegation audits for each delegated credentialing entity.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 06 - Provider Relations	Process for Consultation with Health Care Professionals Regarding CredentialingThe MAO must have a process for health care professionals' input in the credentialing process.	Submit to CMS a detailed description of Arcadian Health Plans credentialing process including the delegated credentialing for the plans contracted network. Identify where and when peer review occurs and how it is integrated into the AHP credentialing/recredentialing process.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.	Describe the actions Arcadian Health Plan is taking to assure the downstream contacts between groups and their individual physicians contain the Medicare required language. The corrective action must include regular internal auditing of contracts to assure compliance and a timetable for compliance.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	Arcadian Health Plan, Inc. (Arcadian) must establish and maintain effective oversight and control of grievance and reconsideration operations to ensure Arcadian staff identify and process grievances and reconsiderations, timely and appropriately. The corrective action plan (CAP) must describe the types of oversight activities Arcadian will implement. The CAP should, at a minimum, include the following: -Arcadian must develop and implement a policy and procedure to effectively monitor the receipt and processing of standard and expedited grievances and reconsiderations. --Arcadian must conduct training to staff on its policies and procedures to ensure grievances and reconsiderations are identified and processed timely and appropriately. Submit documentation to the Regional Office that details the nature of the training, including (1) the date(s) of the training, (2) materials used in the training, (3) the individuals conducting the training, and (4) individuals being trained. -Arcadian must be able to produce valid universe listings for grievances and reconsiderations so that CMS can select another review sample for a focused review to occur later during the year. --Arcadian must conduct an audit each month to evaluate accurate selection of the grievance and reconsideration universes and to ensure compliance with CMS grievance and reconsideration monitoring elements. Arcadian should submit a summary report each quarter to the CMS Regional Office, of monthly audit findings, until further notified by CMS. The summary report should include: name and title of the auditor(s), the audit methodology and the audit findings. If problem areas are identified, please provide CMS with a copy of the CAP implemented by Arcadian in order to resolve the problem(s).	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	See Corrective Action Required for element GV01.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	See Corrective Action Required in element GV01.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	See Corrective Action Required in GV01.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Arcadian must establish and maintain effective oversight and control over its claims processing operations to ensure processors develop and deny non-contracting provider claims appropriately and propose a corrective action plan that describes the types of oversight activities it will implement. The CAP should at a minimum include the following: -Arcadian must conduct training to staff on its policies and procedures to ensure non-contracted provider claims are adjudicated appropriately by Arcadian or its Subcontracted Entity - Vision Service Provider (VSP). -Submit documentation to the Regional Office that details the nature of the training, including (1) the date(s) of the training, (2) materials used in the training, (3) the individuals conducting the training, and (4) individuals being trained. -Arcadian must conduct an audit each month to evaluate the selection of the denied claims universe, development and adjudication of non-contracted provider claims, and notification to the member of the denials. Arcadian should submit a summary report each quarter to the Regional Office of its monthly findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, and the results of the audit. If deficiencies are identified, please provide us with a copy of the corrective action plan to resolve the problem. On July 31, 2006, Arcadian issued an educational bulletin to staff reminding them of the correct procedure for "Handling Unclean Claims" (OPS-030)from non-contracted providers before denying the claim for no prior authorization. OPS-030 must be revised to ensure all unclean claims are either paid or denied within 60 days of receipt. If additional information is requested and not received, Arcadian must make a payment or denial determination based on the available information rather than closing the claim until the documentation is received. Claims development procedures should also include contacting the contracted primary care physician or specialist to determine if the member was referred to the non-contracted provider when necessary.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Arcadian must analyze the interest payment process to determine the cause of the interest calculation error. Submit to CMS your analysis, corrective action, and the estimated date of completion.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Arcadian must ensure all members receive a written denial notice for non-contracted provider claim denials. Refer to Corrective Action Required in Element OC01 for staff training, claims operations oversight and reporting requirements.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	Arcadian must revise the policy and procedures to identify payers that are primary to Medicare, identify the amounts payable by those payers, and coordinate its benefits to Medicare enrollees with the benefits of the primary payers. Additional information is available in the Medicare Managed Care Manual, Chapter 4 Benefits and Beneficiary Protection, Section 80 Medicare Secondary Payer Procedures.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions Arcadian Health Plan is taking to assure meeting the 14 calendar day processing of standard organization determinations in accordance with CMS policy and regulations.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Describe the actions Arcadian Health Plan is taking to assure that it issues the CMS required NDMC.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Describe actions Arcadian Health Plan is taking to assure meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5416	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Arcadian Health Plan, Inc. (Arcadian) must establish and maintain effective oversight and control of reconsideration operations to ensure Arcadian staff receive and process appeals, timely and appropriately. The corrective action plan (CAP) must describe the types of oversight activities Arcadian will implement. The CAP should, at a minimum, include the following: -Arcadian must develop and implement a policy and procedure to effectively monitor the receipt and processing of standard and expedited reconsiderations. -Arcadian must be able to produce a valid reconsideration universe so that CMS can select another review sample for a focused review that will be scheduled at a later date. --Arcadian must conduct an audit each month to evaluate accurate selection of the reconsideration universes and to ensure compliance with CMS reconsideration monitoring elements. Arcadian should submit a summary report each quarter to the CMS Regional Office, of monthly audit findings, until further notified by CMS. The summary report should include: name and title of the auditor(s), the audit methodology and the audit findings. If problem areas are identified, please provide CMS with a copy of the CAP implemented by Arcadian in order to resolve the problem(s).	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.	Arcadian must develop and provide documentation to CMS that the above mentioned items will be available to beneficiaries upon request.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	Arcadian must review its welcome call policy and scripts to ensure it complies with CMS requirements and that this policy is implemented in all market areas. A copy of the welcome call policy must be submitted to our office for review. Also, forward a copy of any follow up activity to the internal audit for this element, including ongoing monitoring reports for each market area to ensure compliance with this element.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Arcadian must ensure its marketing representatives and brokers receive the same level of training on the MA product. Arcadian must also ensure marketing oversight is consistent between its marketing representatives and brokers, and that all files are updated accordingly. In addition, we also recommend Arcadian develop a more formal process to effectively train and to monitor marketing representative and broker performance for all market areas especially where rapid disenrollment statistics are higher than Plan standards. This process may include: - All marketing representatives and brokers and agents to sign a MA Sales Code of Coduct on an annual basis. This document would clearly state code of conduct violations regarding enrollment applications, HIPAA Guidelines, Events and Giveaways, Prohibited Solicitation, and other applicable information from Chapter 2 Enrollment and Chapter 3 Marketing Guides. - All sales representatives and brokers/agents receive compliance training on Medicare Part D Fraud, Waste and Abuse at time of employment and annually thereafter. A signed compliance statement of attestation and certification after completion of the training should be included in all sales personnel files. - All sales representatives sign a Medicare Prescription Drug Plan Marketing Compliance Requirement document that clearly states critical information that the sales representative agrees to comply with for Medicare Part D sales, along with the CMS Marketing Guidelines. - A database to monitor performance and identify issues and areas where additional training updates can improve overall performance. A database should be developed for all sales personnel that will allow Arcadian to profile by market area, issue, sales representative, broker or agent, and by overall volume of complaints. The corrective action plan must describe the types of oversight activities and process improvements Arcadian will implement to effectively monitor the sales operations. Also include a schedule of training and submit a copy of traning materials that will be used.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 03 - Marketing	Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.	Describe actions Arcadian Health Plan is taking to assure meeting the written notice to Medicare members 30 days prior to the termination of his/her PCP in accordance with CMS policy and regulations. The process must include internal audits to assure compliance with CMS requirements.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Access to Care - The MAO has written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS, continuously monitors its provider networks' compliance with these standards, and takes corrective action as necessary. The MAO ensures that the hours of operation of its providers are convenient to and do not discriminate against members. When medically necessary, the MAO makes services available 24 hours a day, 7 days a week.	Submit to CMS all access and availability audits conducted on the plan's contracted network since the initiation of the CMS contract 1/1/05 and evidence that these audits were reported to the QI committee.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	Submit to CMS a signed copy of 2006 UM Program and minutes from the executive board that the UM program was reviewed and approved by the policy oversight body, executive board.	Closed
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Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Describe the actions Arcadian Health Plan is taking to assure it initially credentials and recredentials its contracted providers in accordance with CMS requirements. The corrective action must include regular internal auditing of credentialing files to assure compliance. Arcadian Health Plan must immediately develop, implement and submit to CMS a credentialing oversight process to assure groups delegated responsibility for credentialing meet CMS requirements. This oversight process must include regular audits of credentialing files and include a corrective action process for any deficiencies found. Submit to CMS the initial pre delegation audits for each delegated credentialing entity.	Closed
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Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	See Corrective Action Required in element GV01.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	See Corrective Action Required in GV01.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Arcadian must establish and maintain effective oversight and control over its claims processing operations to ensure processors develop and deny non-contracting provider claims appropriately and propose a corrective action plan that describes the types of oversight activities it will implement. The CAP should at a minimum include the following: -Arcadian must conduct training to staff on its policies and procedures to ensure non-contracted provider claims are adjudicated appropriately by Arcadian or its Subcontracted Entity - Vision Service Provider (VSP). -Submit documentation to the Regional Office that details the nature of the training, including (1) the date(s) of the training, (2) materials used in the training, (3) the individuals conducting the training, and (4) individuals being trained. -Arcadian must conduct an audit each month to evaluate the selection of the denied claims universe, development and adjudication of non-contracted provider claims, and notification to the member of the denials. Arcadian should submit a summary report each quarter to the Regional Office of its monthly findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, and the results of the audit. If deficiencies are identified, please provide us with a copy of the corrective action plan to resolve the problem. On July 31, 2006, Arcadian issued an educational bulletin to staff reminding them of the correct procedure for "Handling Unclean Claims" (OPS-030)from non-contracted providers before denying the claim for no prior authorization. OPS-030 must be revised to ensure all unclean claims are either paid or denied within 60 days of receipt. If additional information is requested and not received, Arcadian must make a payment or denial determination based on the available information rather than closing the claim until the documentation is received. Claims development procedures should also include contacting the contracted primary care physician or specialist to determine if the member was referred to the non-contracted provider when necessary.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Arcadian must analyze the interest payment process to determine the cause of the interest calculation error. Submit to CMS your analysis, corrective action, and the estimated date of completion.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Arcadian must ensure all members receive a written denial notice for non-contracted provider claim denials. Refer to Corrective Action Required in Element OC01 for staff training, claims operations oversight and reporting requirements.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	Arcadian must revise the policy and procedures to identify payers that are primary to Medicare, identify the amounts payable by those payers, and coordinate its benefits to Medicare enrollees with the benefits of the primary payers. Additional information is available in the Medicare Managed Care Manual, Chapter 4 Benefits and Beneficiary Protection, Section 80 Medicare Secondary Payer Procedures.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Describe actions Arcadian Health Plan is taking to assure meeting the 14 calendar day processing of standard organization determinations in accordance with CMS policy and regulations.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Describe the actions Arcadian Health Plan is taking to assure that it issues the CMS required NDMC.	Closed
Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Describe actions Arcadian Health Plan is taking to assure meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations.	Closed

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Arcadian Management Services Inc.	1-510-817-1036	H5700	MA	Audit Findings	6/4/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Arcadian Health Plan, Inc. (Arcadian) must establish and maintain effective oversight and control of reconsideration operations to ensure Arcadian staff receive and process appeals, timely and appropriately. The corrective action plan (CAP) must describe the types of oversight activities Arcadian will implement. The CAP should, at a minimum, include the following: -Arcadian must develop and implement a policy and procedure to effectively monitor the receipt and processing of standard and expedited reconsiderations. -Arcadian must be able to produce a valid reconsideration universe so that CMS can select another review sample for a focused review that will be scheduled at a later date. --Arcadian must conduct an audit each month to evaluate accurate selection of the reconsideration universes and to ensure compliance with CMS reconsideration monitoring elements. Arcadian should submit a summary report each quarter to the CMS Regional Office, of monthly audit findings, until further notified by CMS. The summary report should include: name and title of the auditor(s), the audit methodology and the audit findings. If problem areas are identified, please provide CMS with a copy of the CAP implemented by Arcadian in order to resolve the problem(s).	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.	According to 42 CFR 422.60.3 Manual Chapter 2 section 40.2.2 Health Sun must correctly identify incomplete enrollment elections and follow CMS requiriements for requesting information from the beneficiaries to make the elections complete. Policies and procedures must be written that describe the following 1. CMS Notice requirements 2. CMS timeframes 3. Enrollment procedures 4. Denial of enrollment procedures Provide a copy of all revised notices to the Region IV Plan Manager for review and approval. Provide a copy of the revised policies and procedures to the Region IV Plan Manager for review.	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	1. Update all policies and procedures to ensure compliance in accordance with 42 CFR 422.60(3)(3), and the Medicare Managed Care Manual Chapter 2 section 40.2.3. 2. Ensure a procedure is in place to review correspondence for correctness and required CMS language prior to mailing to members. 3. Ensure a process and procedure is in place to routinely review documentation regarding denial of enrollment. These may include polices and procedures, complaint/grievance logs, and beneficiary correspondence regarding denial of enrollment.	Closed

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Notice Content) - The denial notice meets CMS requirements. If the MA plan is currently enrolled to capacity, the notice explains the procedures that will be followed when vacancies occur.	1. Update all policies and procedures to ensure compliance in accordance with 42 CFR 422.60(3)(3), and the Medicare Managed Care Manual Chapter 2 section 40.2.3. 2. Ensure a procedure is in place to review correspondence for correctness and required CMS language prior to mailing to members. 3. Ensure a process and procedure is in place to routinely review documentation regarding denial of enrollment. These include polices and procedures, complaint/grievance logs, and beneficiary correspondence regarding denial of enrollment. 4. Develop a process to ensure correct notices are provided to the members according to CMS notice requirements and timeframes.	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Appropriate Follow-Up on Changes in State and County Code - The MAO reviews the CMS Monthly Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follows-up on any change in residence for its members reported to it by CMS.	1. Policies and procedures should be updated to reflect compliance with regulations in 42 CFR 422.50(a)(3) and CMS guidelines and regulations as of the date of this report. 2. Provide training and staff development to appropriate staff members concerning this required process. Please provide CMS with a description of this training along with attendance and signature pages. 3. Provide quarterly audit reports for a period of six (6) months documenting the status of the corrective action required.	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	Health Sun Health Plan must revise its policies and procedures to include language which outlines procedures for the submission of English and non-English marketing material. Health Sun Health Plan must also revise its policies and procedures to include language which outlines procedures for the submission of appropriate member notices according to the summary of notice requirements located in Chapter 2 of the Managed Care Manual. Health Sun Health Plan must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, to include: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 03 - Marketing	Disclosure of Required Non-Deemable Information to Beneficiaries - At the time of enrollment and annually thereafter, an MAO must disclose to each beneficiary electing an MA plan, in clear, accurate and consistent form the information required by CMS.	Health Sun Health Plan must develop and implement policies and procedures on Appendix 1 of Chapter 2, Enrollment and Disenrollment Summary of Notice Requiriements. Health Sun Health Plan must conduct training on Chapter 2 Enrollment and Disenrollment for appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, to include: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	1. Update all policies and procedures to ensure compliance with 42 CFR 422.60(3)(3), Manual Chapter 2 section 40.2.3. 2. Develop policies to support CMS requirements related to denial of enrollment prior to transmission of CMS data. 3. Develop a process for reviewing complaint/grievance logs and routinely used beneficiary correspondence that may identify any deficiencies regarding denial of enrollment. 4. Develop a process for denial of enrollment prior to transmission to CMS to determine timeliness of notices according to timeframes specified by CMS. 5. Provide a copy of the updated policies and procedures to the Region IV Plan Manager. 6. Provide a quarterly audit report for a period of six (6) months to determine whether the enrollments are submitted according to CMS timeframes.	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	1. Update all policies and procedures to ensure compliance in accordance with 42 CFR 422.500,422.520a,1 - Manual Ch. 11-Section 100.2 and Ch. 13 - Section 40.1 2. Ensure an effective system is in place to process all claims received at Health Sun Health Plan in accordance with CMS specified timeframes. 3. Health Sun Health Plan must provide CMS with a copy of the updated policies and procedures. 4. Health Sun Health Plan must submit monthly claims payment reprots to the Atlanta regional office beginning the first of June, and continue for a period of of time not less than six months.	Closed
HealthSun Health Plans, Inc	1-305-234-9292 Ext. 222	H5431	MA	Audit Findings	5/25/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	1. Update all policies and procedures to ensure compliance in accordance with 42 CFR 422.520a,2 Manual Ch. 11 Section 100.2 2. Ensure an effective system is in place to process all claims received at Health Sun Health Plan in accordance with CMS specified timeframes. 3. Health Sun Health Plans must provide the Region IV Plan Manager with a copy of the updated policies and procedures. 4. Process each claim identified as out of compliance and submit the correct amount of interest owed on each claim to the appropriate provider. 5. Provide a copy of the documentation to the Region IV Plan Manager to show the difference in the correct amount owed and what was already paid on each claim.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	MemberHealth must revise its policies and procedures to include the following provisions: - to conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines, and -a requirement that all persons marketing on behalf of the Part D sponsor be state licensed, certified or registered individuals. MemberHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with documentation that its marketing program monitoring activities confirm that MemberHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. MemberHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following provisions: (1) a provision prohibiting payment by the person performing marketing to beneficiaries, (2) a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short time frame, (3) a provision requiring any person directly employed or contracted to market on behalf of MemberHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with MemberHealth. The person may be compensated based on your enrollment in a plan,' and (4) a provision for coordinated marketing. It must also ensure that all contracts are signed by all appropriate parties. Member Health must provide a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, MemberHealth must ensure that it provides a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. MemberHealth must provide documentation to CMS demonstrating that it provides written notice to affected enrollees within 60 days prior to the change, or provides an affected enrollee with a 60-day supply of the drug under the same terms as well as written notice of the formulary change at the time a refill of the drug is requested.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits.	MemberHealth must revise its policies and procedures to include a provision that states that it must offer standard contracting terms and conditions, including performance and service criteria for long-term care pharmacies that CMS specifies, to any long-term care pharmacy in its service area that requests the contract. MemberHealth must conduct training of its staff responsible for long-term care network contracting and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	MemberHealth must revise its policies and procedures to include a provision with a description of the procedures for providing a notice of 'maintenance' formulary changes to SPAPs and entities providing other prescription drug coverage, in accordance with CMS requirements. MemberHealth must revise its policies and procedures to include a provision with a description of the procedures for providing a notice of 'other' formulary changes to SPAPs and entities providing other prescription drug coverage, in accordance with CMS requirements. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	MemberHealth must revise its policies and procedures to include a provision to abide by extensions to the transition period in accordance with CMS policy. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must submit system reports regarding its transition process utilization for LTC residents to demonstrate that: - It correctly implements the transition process for LTC residents as described in its policies and procedures and that is consistent with its contractual requirements, and - It has and implements a transition process that covers an emergency supply or 'first-fill' of non-formulary Part D drugs.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies.	MemberHealth must amend its long-term contract addenda to include a provision to require the pharmacy to provide price differential information to Part D plans for inclusion in the written Explanation of Benefits. MemberHealth must provide a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	MemberHealth must provide CMS with a notice consistent with CMS-issued model notice for `Medicare Prescription Drug Coverage and Your Rights.' If MemberHealth does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	MemberHealth must revise its policies and procedures to include provisions for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. MemberHealth must revise its policies and procedures to define coverage determinations in accordance with §423.566(b) (1-5). MemberHealth's policies and procedures must include a provision for quarterly reporting of all data requested in Reporting Requirements Section VII: Appeals. MemberHealth must provide documentation to CMS demonstrating that it has developed and implemented systems to track and address in a timely manner enrollees' oral and written requests for exceptions, coverage determinations, and redeterminations and more specifically systems to track at a minimum the date of receipt, date of notification, disposition of request and date of disposition. MemberHealth must conduct training of appropriate staff on these policies, procedures, and systems and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	MemberHealth must revise its policies and procedures to include provisions stating that MemberHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but not later than 72 hours after receipt of the request, or for an exceptions request, the physician's supporting statement. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must notify enrollees of standard coverage determinations concerning benefits within the CMS-approved timeframe and provide documentation of this to CMS.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	MemberHealth must revise its policies and procedures to address the requirements for coverage determinations concerning payment. Specifically, these policies and procedures must include provisions stating: - MemberHealth must notify the enrollee of its coverage determination regarding payment decision no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - for favorable coverage determinations concerning payment, MemberHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - for favorable coverage determinations concerning payment, MemberHealth must make payment within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	MemberHealth must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or applicable party). MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. The OMB control number must be displayed in the upper right hand corner of the notice, as required by CMS. MemberHealth must conduct training of appropriate staff on the use of the appropriate notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination; The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	MemberHealth must revise its policies and procedures to include provisions discussing a means for making expedited coverage determination decisions within the appropriate timeframe for requests received outside of normal business hours. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	MemberHealth must revise its policies and procedures to include a provision for timeliness of expedited coverage determination denial notification in accordance with CMS requirements. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	MemberHealth must revise its policies and procedures for enrollee notification following a decision to deny a request for an expedited coverage determination to include the following provisions: - _____ oral and written notice must provide an explanation that MemberHealth must process the request using the 72 hour timeframe for standard determinations, - _____ oral and written notice must inform the enrollee of the right to file an expedited grievance, - oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support, and - _____ oral and written notice must provide instructions about MemberHealth¿s grievance process and its timeframes. MemberHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with a CMS-approved notice template that is consistent with CMS-issued Notice of Right to an Expedited Grievance. If MemberHealth does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. MemberHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	MemberHealth must revise its policies and procedures to include provisions stating that: -MemberHealth must make an expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement, - if a expedited coverage determination decision is adverse and MemberHealth first notifies the enrollee of the determination orally, MemberHealth must mail written confirmation to the enrollee within 3 calendar days of the oral notification, and -MemberHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. MemberHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	MemberHealth must revise its policies and procedures to include a provision stating that if the decision on an expedited coverage determination is adverse, MemberHealth must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. Policies and procedures must also include a provision stating that if oral notice is provided for adverse decision, the notice must satisfy the following requirements: -state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. The OMB control number must be displayed in the upper right hand corner of the notice, as required by CMS. MemberHealth must conduct training of appropriate staff on the use of the appropriate notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	MemberHealth must revise its policies and procedures to include provisions stating that: - if MemberHealth requires a written statement from the enrollee's prescribing physician, it must do so immediately, - the prescribing physician's statement must indicate that the preferred drug for the treatment of the enrollee's condition (1) would not be effective as the requested drug and/or (2) would have adverse effects, - the prescribing physician is required to demonstrate in its written statement one of the following two factors: that a preferred drug for the treatment of an enrollee's condition (1) would not be effective as the requested drug and/or (2) would have adverse effects, - if MemberHealth makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, and -MemberHealth must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. MemberHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	MemberHealth must revise its policies and procedures to include provisions stating that the prescribing physician's statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because: (1) All covered Part D drugs on any tier of MemberHealth's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, or (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. Additionally, MemberHealth must revise its policies and procedures to state that: - MemberHealth must grant a formulary exception when it determines that one of the three factors discussed above has been demonstrated, and the drug would be covered, but for the fact that it is an off-formulary drug, and - if MemberHealth makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	MemberHealth must revise its policies and procedures to include provisions stating that: - coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, - enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and - all approved non-formulary drugs must be placed in existing cost-sharing tier(s). MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide documentation to CMS demonstrating that it places all approved non-formulary drugs in existing cost-sharing tiers and provide coverage for approved tiering exceptions at the same cost-sharing tier as preferred drugs. Additionally, MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	MemberHealth must revise its policies and procedures to include provisions for promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals. MemberHealth must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide documentation to CMS demonstrating its communication methods for informing enrollees of complaint categorization. MemberHealth must provide documentation to CMS demonstrating that it has a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. MemberHealth must provide CMS with an analysis and explanation of why the universes submitted for WS-CD2_D, Standard Coverage Determinations Concerning Payments, and WS-CD3_D, Expedited Coverage Determinations, contain misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	MemberHealth must revise its grievance policies and procedures to include a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	MemberHealth must revise its policies and procedures to include provisions stating that: - all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but not later than 30 days after MemberHealth receives the oral or written grievance, - the 30-day timeframe may be extended by 14 days or less if the enrollee requests the extension or if MemberHealth justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - the enrollee must immediately be notified in writing when MemberHealth extends the deadline. MemberHealth must conduct training of Customer Service, Grievance, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must submit documentation to CMS demonstrating that it notifies enrollees of grievance resolutions within the CMS-approved timeframes.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	MemberHealth must revise its policies and procedures and found they do not include provisions stating: - all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing, and - MemberHealth's commitment to cooperating with the QIO in resolving grievance cases. MemberHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	MemberHealth must conduct training of appropriate staff on policies and procedures for expedited grievances and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	MemberHealth must revise its policies and procedures to include a provision for providing a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide documentation to CMS demonstrating that it has developed and implemented a system to accept written requests from the enrollee for a redetermination within the 60 calendar day timeframe in order to meet the CMS compliance standards for RE01. MemberHealth must conduct training of appropriate staff on these policies and procedures and this system and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Additionally, MemberHealth must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D and WS-RE2_D contained misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	MemberHealth must provide documentation to CMS demonstrating that it has implemented a system for accepting oral and written requests for expedited redeterminations that maintains documentation of expedited redetermination requests in case files. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	MemberHealth must revise its policies and procedures to include provisions stating that: -MemberHealth automatically expedites a request when the enrollee's physician indicates that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, and - any additional medical information MemberHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. MemberHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	MemberHealth must revise its policies and procedures to include provisions stating that: -MemberHealth must transfer denied requests for an expedited redetermination to the standard redetermination timeframe, and - MemberHealth must provide prompt oral notice to the enrollee, and provide equivalent written notice within 3 calendar days of the oral notice. MemberHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. MemberHealth must provide CMS with a CMS-approved notice template that is consistent with the CMS-issued Notice of Right to an Expedited Grievance. If MemberHealth does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. MemberHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	MemberHealth must revise its policies and procedures to include a provision for effectuating the favorable redetermination as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination. MemberHealth must also revise its policies and procedures to include a provision stating that MemberHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contained misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	MemberHealth must revise its policies and procedures to include a provision stating that for favorable redeterminations to the enrollee, MemberHealth must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. MemberHealth must also revise its policies and procedures to include a provision stating that MemberHealth must inform the enrollee, within 24 hours, when their case is forwarded to the IRE. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	MemberHealth must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing, - indicating that the initial notification of an adverse decision may be made orally, so long as a follow-up written decision is mailed within 3 calendar days of the oral notification, - stating that medical information must be requested within 24 hours of the enrollee's initial request, and - stating that MemberHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	MemberHealth must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	MemberHealth must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, WS-RE2_D, and WS-RE3_D contain misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently. MemberHealth must provide documentation to CMS demonstrating that it uses appropriate personnel to conduct redeterminations.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	MemberHealth must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, WS-RE2_D, and WS-RE3_D contain misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	MemberHealth must demonstrate to CMS that it effectuates a standard reconsideration decision that has been reversed by the IRE for appeal cases concerning drug benefit within the timeframes required by CMS and must notify the IRE of the effectuation of any reconsideration decision that fully or partially reverses MemberHealth's redetermination decision. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contained misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	MemberHealth must revise its policies and procedures to include a provision stating that payment must be made no later than 30 days from the date MemberHealth receives notice reversing the decision. MemberHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Universal American Corp.	1-440-248-8448 Ext. 345	S5803	Part D	Audit Findings	5/25/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	MemberHealth must revise policies and procedures to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. MemberHealth must conduct training of appropriate staff on effectuation of third party reversals policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. MemberHealth must demonstrate to CMS that it effectuates an expedited reconsideration decision that has been reversed by the IRE for appeal cases concerning drug benefit within the timeframes required by CMS and must notify the IRE of the effectuation of any reconsideration decision that fully or partially reverses MemberHealth's redetermination decision. MemberHealth must provide CMS with an analysis and explanation of why the universe submitted for WS-RE3_D contains misclassified samples. Based on the analysis, MemberHealth is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	The MAO must identify and update marketing materials with the correct Customer Service hours of 8am to 8pm, 7 days a week. The MAO must provide the RO with a list of documents revised.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 05 - Quality Assurance	Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.	The MAO must conduct routine monthly audits of its delegates and provide senior management with reports that reflect the individual delegate's performance and ability to comply with CMS standards. The MAO must submit a summary of its monthly delegate audits and a list and description of the internal reports it will develop and submit to senior management that reflects the performance of its delegates to the Regional Office per the instructions of the Regional Office Plan Manager. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	The MAO must develop a process to ensure that provider quality of care complaints are incorporated into the MAO's recredentialing process. Polices and procedures in this area must clearly map workflow and assigned responsibilities between departments in order to ensure that provider quality of care complaints and their completed resolution are incorporated in the provider recredentialing process and provided to the appropriate committee official prior to final approval.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	The MAO will be required to submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. In addition the organization must also: 1. Develop grievance polices and procedures that demonstrate coordination between member services and other departments in a consistent manner. Polices and procedures must clearly map the workflow of grievance staff, including but not limited to the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 2. Develop grievance policies and procedures that detail how the MAO staff and its delegates identify and appropriately address and resolve complaints related to quality of care. 3. Develop a process to ensure provider and facility, quality of care complaint information is shared with provider relation and credentialing staff 4. Develop efficient oversight and management of grievance responsibilities by: appropriate and consistent documentation of grievances, to include quality of care complaints, appropriately tracking all grievances, correctly distinguishing a grievance from an appeal, and promptly and consistently transferring appeal issues to the appeals department staff. 5. Develop internal monthly audit processes that adhere to the Medicare grievance requirements, for the MAO and its delegates. 6. Develop processes to ensure that grievances are categorized appropriately in the MAO's system and tracked until they are appropriately resolved. 7. Develop a process that will allow the MAO to maintain, aggregate, and analyze grievance data based on the nature of the issues raised by its beneficiarys. 8. Develop a comprehensive management report that will allow senior management to evaluate member complaints and identify and address potential areas of improvement, additional staff education, and improve member and provider satisfaction over time	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	The MAO will be required to submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. In addition the organization must also: 1. Develop grievance polices and procedures that demonstrate coordination between member services and other departments in a consistent manner. Polices and procedures must clearly map the workflow of grievance staff, including but not limited to the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 2. Develop grievance policies and procedures outlining how the MAO staff and its delegates identify and appropriately address all complaints related to quality of care. 3. Develop a process to ensure provider and facility, quality of care complaint information is shared with provider relation and credentialing staff 4. Develop efficient oversight and management of grievance responsibilities by: appropriate and consistent documentation of grievances, to include quality of care complaints, appropriately tracking all grievances, accurately distinguishing a grievance from an appeal, and promptly and consistently transferring appeal issues to the appeals department staff. 5. Develop internal monthly audit processes of Medicare grievance requirements for the MAO and its delegates. 6. Develop processes to ensure grievances are accurately categorized in the MAOs system and tracked until they are appropriately resolved. 7. Develop a process that allows the MAO to maintain, aggregate, and analyze grievance data based, on the nature of the issue or complaint raised by members. 8. Develop comprehensive management reports allowing senior management the ability to evaluate member complaints and identify and address potential areas of improvement, additional staff education, that would improve member and provider satisfaction.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	The MAO will be required to submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. In addition the organization must also: 1. Develop grievance polices and procedures that demonstrate coordination between member services and other departments in a consistent manner. Polices and procedures must clearly map the workflow of the grievance process, including but not limited to the identification of each specific step, grievance task, responsibility, and day-to-day oversight of the grievance requirements. 2. Develop grievance policies and procedures that outline how the MAO staff and its delegates identify and appropriately resolve complaints related to quality of care. 3. Develop a process to ensure provider and facility, quality of care complaint information is shared with provider relation and credentialing staff 4. Develop efficient oversight and management of grievance responsibilities by: appropriate and consistent documentation of grievances, to include quality of care complaints, appropriately track grievances, accurately distinguishing a grievance from an appeal, and promptly and consistently transferring appeal issues to the appeals department staff. 5. Develop internal monthly audit processes of Medicare grievance requirements for the MAO and its delegates. 6. Develop processes to ensure that grievances are accurately categorized in the MAO's system and tracked until they are appropriately resolved. 7. Develop a process that allows the MAO to maintain, aggregate, and analyze grievance data based on the nature of the issue or complaint raised by members. 8. Develop a comprehensive management report that allows senior management to evaluate member complaints and identify and resolve potential areas of improvement, additional staff education, and improve member and provider satisfaction.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	The MAO will be required to submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. In addition the organization must also: 1. Develop grievance polices and procedures that demonstrate coordination between member services and other departments in a consistent manner. Polices and procedures must clearly map the workflow of grievance staff, including but not limited to the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 2. Develop grievance policies and procedures that outline how the MAO staff and its delegates identify and appropriately address complaints related to quality of care. 3. Develop a process to ensure provider and facility, quality of care complaint information is shared with provider relation and credentialing staff 4. Develop efficient oversight and management of grievance responsibilities by: appropriate and consistent documentation of grievances, including quality of care complaints, appropriately tracking grievances, accurately distinguishing a grievance from an appeal, and promptly and consistently transferring appeal issues to the appeals department staff. 5. Develop internal monthly audit processes of Medicare grievance requirements for the MAO and its delegates. 6. Develop processes to ensure that grievances are accurately categorized in the MAO's system and tracked until they are appropriately resolved. 7. Develop a process that allows the MAO to maintain, aggregate, and analyze grievance data based on the nature of the issues or complaint raised by members. 8. Develop a comprehensive management report that allows senior management to evaluate member complaints and identify and resolve potential areas of improvement, additional staff education, and improve member and provider satisfaction.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	1. The MAO must revise/develop policies and procedures to instruct claims processing staff to develop for missing or incorrect claim information when a beneficiary is held liable. The MAO must conduct training of the appropriate staff on the policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 2. The MAO must conduct an internal audit each month of a denied claim sample. The audit should evaluate whether the claims processor is developing for missing information, prior to issuing a denial. The MAO must submit a summary report monthly to the regional office of its findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, the results of the audit, and any recommendations or resolutions implemented to correct deficiencies identified. 3. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements. 4. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	1. The MAO must revise the following policies and procedures: a) Identifying and adjudicating clean claims and b) Interest payment calculation. 2. The MAO must conduct training of the appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 3. The MAO must conduct an internal audit each month of claims paid within 60 days. This audit should evaluate whether the claims processor calculated interest correctly. The MAO must submit a summary report monthly to the regional office of its findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, the results of the audit, and any recommendations or resolutions implemented to correct deficiencies identified. 4. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements. 5. The MAO must establish a mechanism for identifying, tracking and reporting clean claims activity.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	1. The MAO must conduct training of appropriate staff on applying the appropriate denial message, to ensure the beneficiary has a clear understanding of the service denied and the specific reason for the denial. The MAO must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individual being trained. 2. The MAO must conduct an internal audit each month of denied claims and the denial messages generated on the denial letter. This must evaluate whether the appropriate denial message was provided to the beneficiary was clear and not misleading. The MAO must submit a summary report monthly to the regional office of its findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, and the results. 3. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements. 4. The MAO must provide the regional office with a complete listing of denial codes generated on the member denial letters as well as the denial code messages generated on the provider payment vouchers. 5. The MAO must provide the regional office a sample denial letter, reflecting the correct customer service hours and days as 8am - 8pm, 7 days a week. 6. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	1. The MAO must revise or develop a policy and procedure that includes the Medicare Secondary Payer guidelines. 2. The MAO must conduct training of the appropriate staff on this policy and procedure and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Policies and procedures must be revised to map the workflow in a clear, detailed manner, with identification of each specific step, task, and responsibility, including those of other departments (e.g. Claims, UM, Member Services, Provider Relations, and Medical Director). Polices and procedures should be revised to be more consistent with Medicare regulations with regard to the initial determination or pre-service denials. The MAO must: 1. Develop a formal process to conduct monthly internal audits of Medicare appeals 2. Develop a process to audit its delegate monthly to ensure that Medicare appeals requirements are meet, 3. Develop internal controls to ensure that member denial notices are appropriate, member friendly, and contain appropriate denial reasons, 4. Establish a formal process to ensure that Medicare model letters are updated in a timely manner and that updated materials are disturbed to its delegates 5. Develop a process to ensure that members received correct notices in the appropriate time frame(s) as required by CMS	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	The MAO must: 1. Develop a formal process to conduct monthly internal audits of Medicare appeals, 2. Develop a process to conduct monthly audits of delegates to ensure Medicare appeals requirements are met, 3. Develop internal controls to ensure member denial notices are appropriate, member friendly, and contain appropriate denial reasons, 4. Establish a formal process to ensure member Medicare model letters are updated in a timely manner and updated materials are disturbed to the MAO's delegates 5. Develop a process to ensure members receive correct notices in the appropriate time frame(s) as required by CMS	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MAO must: 1. Develop a formal process to conduct monthly internal audits of Medicare appeals 2. Develop a process to audit its delegate to ensure Medicare appeals requirements are meet in a consistent manner, 3. Develop internal controls to ensure member denial notices are appropriate, member friendly, and contain appropriate denial reasons, 4. Establish a formal process to ensure Medicare model letters are updated in a timely manner and that updated materials are disturbed to its delegates 5. Develop a process to ensure members received correct notices in the appropriate time frame(s) as required by CMS	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	1. Develop a formal process to conduct internal audits of Medicare appeals 2. Develop a process to audit its delegate to ensure Medicare appeals requirements are meet in a consistent manner, 3. Develop internal controls to ensure that member denial notices are appropriate, member friendly, and contain appropriate denial reasons, 4. Establish a formal process to ensure that Medicare model letters are updated in a timely manner and that updated materials are disturbed to its delegates 5. Develop a process to ensure that members received correct notices in the appropriate time frame(s) as required by CMS	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Policies and procedures should be developed or revised to map the workflow in a clear, detailed manner, outlining each step, task, responsibility as well as timeline to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director) if those departments are involved in the process. The MAO must develop internal controls to ensure that favorable claim reconsiderations are adjudicated timely, by its delegate. The MAO must develop a formal process for auditing its delegate monthly, to ensure compliance with Medicare claims and appeals requirements.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	The MAO will be required to submit a new universe and sample case files for Unfavorable Claim Reconsiderations per the RO Plan Manager's instructions. The MAO must develop policies and procedures clearly outlinning the workflow of the appeals process, to include but not limited to the identification of each specific step, task, responsibility and day to day oversight of the reconsideration requirements. The MAO must develop processes to ensure beneficiary claim reconsiderations are accurately categorized separately, from any provider dispute appeal process.	Closed

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Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	The MAO will be required to submit a new universe and sample case files for Unfavorable Claim Reconsiderations per the RO Plan Manager's instructions. The MAO must develop policies and procedures clearly outlinning the workflow of the appeals process, to include but not limited to the identification of each specific step, task, responsibility and day to day oversight of the reconsideration requirements. The MAO must develop processes to ensure beneficiary claim reconsiderations are correctly categorized separate from any provider dispute appeal process.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	Policies and procedures must be developed or revised to outline workflows in a clear, and detailed manner. The workflows must outline each step, task, responsibility, and timeline, to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director). The MAO must develop internal controls to ensure that favorable standard pre-service reconsideration notices are generated and mailed timely.	Closed
Marion Polk Community Health Plan LLC	1-503-371-7701 Ext. 119	H5995	MA	Audit Findings	5/24/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	Policies and procedures must be developed or revised to outline workflows in a clear, detailed manner. Workflows should outline each step, task, responsibility, as well as timeline to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director). The MAO must develop internal controls to ensure that unfavorable pre-service reconsiderations are processed timely.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Elder Health must revise its policies and procedures to include a description of the method(s) used to provide notification of formulary changes, which must include, at a minimum, posting formulary changes on each affected plan's Internet website. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Elder Health must revise its policies and procedures to include the following provisions: - Conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines. - Any person directly employed or contracted to market on behalf of Elder Health is required to provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Elder Health. The person may be compensated based on your enrollment in a plan.' - All persons marketing on behalf of Elder Health must be state licensed, certified or registered individuals. Elder Health must conduct training of appropriate staff to ensure they are aware of these additions to the policies and procedures, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Elder Health must provide CMS with evidence that it confirms, via its ongoing monitoring activities, that its marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Elder Health must also provide CMS with evidence that it has a current contract/compensation structure in effect that includes the following provisions: - Any person directly employed or contracted to market on behalf of Elder Health must provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with Elder Health. The person may be compensated based on your enrollment in a plan.' - Any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal health care laws (including civil monetary penalty laws). Elder Health must also provide CMS with evidence that it has a current employee-specific contract/compensation structure in effect that demonstrates that an actual contractual/ employment relationship exists between Elder Health and its employees, and demonstrates or includes the above provisions as well as those listed below: - A compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans. - A person/agency performing marketing to beneficiaries is prohibited from making payments to beneficiaries. - Payment will be withheld or withdrawn if an enrollee disenrolls in an unreasonably short time frame.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-MR4_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Elder Health must revise its policies and procedures to include the following: - A description of the procedures for providing a notice of 'maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, - A description of the procedures for providing a notice of 'other' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, - A description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, and - A description of the method(s) used to provide notification of formulary changes. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	Elder Health must revise its policies and procedures to include a provision to abide by extensions to the transition period in accordance with CMS policy. Specifically, policies and procedures must describe how Elder Health will continue to provide necessary covered Part D drugs to an enrollee via an extension of the transition period, on a case-by-case basis, to the extent that his or her exception request or appeal has not been processed by the end of the minimum transition period. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Elder Health must ensure that its transition process for residents of long-term care facilities does not require members to request a coverage determination in order to receive an 'emergency supply' or 'first fill' of a non-formulary drug when the member is outside the initial transition period. Elder Health must submit documentation to CMS to demonstrate that its claims system issues an override code for the pharmacist to use in these situations.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies.	Elder Health must provide CMS with a copy of the signed long-term care pharmacy addendum for each sample contract that was missing it. Elder Health must also amend its long-term contract addenda to include a provision to require the pharmacy to provide price differential information to Part D plans for inclusion in the written Explanation of Benefits. Elder Health must provide a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Elder Health must revise its policies and procedures to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices. Also Elder Health must revise its policies and procedures to include a provision stating that if the network or preferred pharmacy is on-site, it must deliver the notice described to the location in the LTC facility designated to accept such notices. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that demonstrates it has developed and implemented procedures to conduct ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception and more specifically that Elder Health's network pharmacies meet the requirement for posting or distributing notices. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Elder Health must revise its policies and procedures to include provisions: - for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits and cost-sharing, and - for tracking and addressing all request for redeterminations. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must notify enrollees of its decision regarding standard coverage determinations concerning benefits within the CMS-approved timeframe, and provide documentation of this to CMS. In cases where Elder Health fails to notify the enrollee of its decision on a coverage determination concerning drug benefit within the required timeframe, Elder Health must forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Elder Health must revise its policies and procedures to include provisions stating that: - Elder Health must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, - Elder Health must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, and - Elder Health must make payment (i.e. mail the payment) within 30 calendar days of the request, or, for an exception request, after receiving the physician's supporting statements. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must notify enrollees of its decision regarding standard coverage determinations concerning payments within the CMS-approved timeframes, and provide documentation of this to CMS.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Elder Health must notify enrollees of an adverse coverage determination decision using a notice consistent with CMS-issued notice `Notice of Denial of Medicare Prescription Drug Coverage', and provide documentation of this to CMS. Elder Health must conduct training of appropriate staff on the use of the appropriate notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination; The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Elder Health must revise its policies and procedures to include: - a provision for discussing the means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, - provisions stating the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, and - a means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must revise its policies and procedures to include a provision stating that Elder Health must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Elder Health must revise its policies and procedures to include a provision stating that if the decision is adverse, then Elder Health must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. Elder Health must revise its policies and procedures to include a provision stating that if oral notice is provided for an adverse decision, the notice must satisfy the following requirements: -state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities and special language requirements, if any, -provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and -provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Elder Health must revise its policies and procedures to include a provision stating that: - if E lder Health requires a written statement from the enrollee's prescribing physician, it must do so immediately, - if Elder Health makes a request for additional supporting medical documentation, Elder Health must clearly identify the type of information that must be submitted, - Elder Health must not keep the exception request open indefinitely when a physician does not submit a supporting statement, - if Elder Health is waiting on a physician's statement in support of a tiering exception request, Elder Health must wait a minimum 96 hours after receiving a standard request or a minimum or 48 hours after receiving an expedited request before issuing its determination on the tiering exception, and - Elder Health must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Elder Health must revise its policies and procedures to include a provision stating: - if Elder Health makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - Elder Health must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if Elder Health is waiting on a physician's statement in support of a formulary exception request, Elder Health must wait a minimum of 96 hours after receiving a standard request or a minimum or 48 hours after receiving an expedited request before issuing its determination on the formulary exception. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Elder Health must revise its policies and procedures to include a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that Elder Health places all approved non-formulary drugs into existing cost-sharing tier(s). Elder Health must provide documentation to CMS that Elder Health provides coverage for approved tiering exceptions at the same cost-sharing level as preferred drugs.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Elder Health must revise its policies and procedures to include provisions for promptly and correctly categorizing complaints as inquiries, grievances or coverage determinations/appeals. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that it has developed and implemented a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees about inquiries involving excluded drugs (consistent with the CMS-issued model notice `Notice of Inquiry Regarding an Excluded Drug'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. E lder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Elder Health must revise its policies and procedures to include: - provisions for transmitting grievances to appropriate decision-making levels when appropriate and in a timely fashion, - a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary, -provisions for tracking and maintaining, at a minimum, the date of receipt, disposition of the grievance and the date that the enrollee was notified of the disposition, and - provisions for quarterly reporting of all data requested in Part D Reporting Requirements Section V: Grievances. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. In addition, Elder Health must develop and implement a system for logging or capturing enrollees' grievances in a centralized location and for tracking and maintaining, at a minimum, the following information, and provide documentation of this to CMS: - Receipt date, - Mode of receipt (e.g., fax, telephone, letter, etc.), - Person or entity that filed the grievance, - Subject of the grievance, - Disposition of the grievance, and - Date Elder Health notified the enrollee of the disposition.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	Elder Health must develop policies and procedures to include a provision for training relevant staff and contractors on grievance policies and procedures. Elder Health must conduct training of appropriate staff to ensure they are aware of this addition to the policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Elder Health must revise its policies and procedures to include provisions stating that: - all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 days after ElderHealth receives the oral or written grievance, - the 30-day timeframe for processing a grievance may be extended by 14 days or less if the enrollee requests the extension or if Elder Health justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - enrollees must immediately be notified in writing when Elder Health extends the deadline for processing a grievance. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with documentation that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Elder Health must use a CMS-approved notice consistent with the CMS-issued model notice `Notice of Plan's Decision Regarding a Grievance' when notifying enrollees in writing of grievance disposition and provide documentation that demonstrates this to CMS. Elder Health must provide documentation to CMS demonstrating the means by which Elder Health responds to standard grievances. Elder Health must conduct training of appropriate staff on the use of the appropriate notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Elder Health must provide documentation to CMS that demonstrates it has developed and implemented procedures for cooperating with QIOs to resolve complaints related to quality of care. Elder Health must conduct training of appropriate staff on these procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	Elder Health must revise its policies and procedures to include a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by Elder Health to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Elder Health must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Elder Health must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Elder Health must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Elder Health must revise its policies and procedures to include a provision stating that any additional medical information that Elder Health requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination.	Closed

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must revise its policies and procedures to include provisions: - for effectuating the favorable redetermination concerning drug benefit as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Elder Health to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Elder Health must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Elder Health must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Elder Health to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Elder Health must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing, - stating that medical information must be requested within 24 hours of the enrollee's initial request, - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Elder Health to forward the enrollee's request to the IRE within 24 hrs of the expiration of the adjudication timeframe, and - stating that Elder Health must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Elder Health must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72 hour timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Elder Health has a system for expedited coverage determination reversals. Elder Health must provide documentation to CMS that it provides timely notification of expedited redetermination decisions.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Elder Health must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Elder Health must revise its policies and procedures to include a provision stating that if the issue is a denial based on lack of medical necessity, then Elder Health must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that Elder Health uses appropriate personnel to conduct redeterminations. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Elder Health must revise its policies and procedures to include a provision stating that: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file, and - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at is designated fax number. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that Elder Health forwards untimely cases to the IRE. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Elder Health must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision, and - include a provision requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice 'Notice of Effectuation to Part D Independent Review Entity'). If ElderHealth does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. E lder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Elder Health must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision, - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision, and - requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice 'Notice of Effectuation to Part D Independent Review Entity'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Bravo Health, Inc.	1-410-864-4437	S1566	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Elder Health must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision, and - include a provision requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice 'Notice of Effectuation to Part D Independent Review Entity'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	Elder Health must revise its policies and procedures to include a description of the method(s) used to provide notification of formulary changes, which must include, at a minimum, posting formulary changes on each affected plan's Internet website. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	Elder Health must revise its policies and procedures to include the following provisions: - Conduct ongoing monitoring of all persons directly employed or contracted to perform marketing to ensure that they comply with all applicable laws and CMS policies, including CMS marketing guidelines. - Any person directly employed or contracted to market on behalf of Elder Health is required to provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Elder Health. The person may be compensated based on your enrollment in a plan.' - All persons marketing on behalf of Elder Health must be state licensed, certified or registered individuals. Elder Health must conduct training of appropriate staff to ensure they are aware of these additions to the policies and procedures, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Elder Health must provide CMS with evidence that it confirms, via its ongoing monitoring activities, that its marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. Elder Health must also provide CMS with evidence that it has a current contract/compensation structure in effect that includes the following provisions: - Any person directly employed or contracted to market on behalf of Elder Health must provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Elder Health. The person may be compensated based on your enrollment in a plan.' - Any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal health care laws (including civil monetary penalty laws). Elder Health must also provide CMS with evidence that it has a current employee-specific contract/compensation structure in effect that demonstrates that an actual contractual/ employment relationship exists between Elder Health and its employees, and demonstrates or includes the above provisions as well as those listed below: - A compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans. - A person/agency performing marketing to beneficiaries is prohibited from making payments to beneficiaries. - Payment will be withheld or withdrawn if an enrollee disenrolls in an unreasonably short time frame	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-MR4_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Elder Health must revise its policies and procedures to include the following: - A description of the procedures for providing a notice of 'maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, - A description of the procedures for providing a notice of 'other' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, - A description of the procedures for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, and - A description of the method(s) used to provide notification of formulary changes. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	Elder Health must revise its policies and procedures to include a provision to abide by extensions to the transition period in accordance with CMS policy. Specifically, policies and procedures must describe how Elder Health will continue to provide necessary covered Part D drugs to an enrollee via an extension of the transition period, on a case-by-case basis, to the extent that his or her exception request or appeal has not been processed by the end of the minimum transition period. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Elder Health must ensure that its transition process for residents of long-term care facilities does not require members to request a coverage determination in order to receive an 'emergency supply' or 'first fill' of a non-formulary drug when the member is outside the initial transition period. Elder Health must submit documentation to CMS to demonstrate that its claims system issues an override code for the pharmacist to use in these situations.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies.	Elder Health must provide CMS with a copy of the signed long-term care pharmacy addendum for each sample contract that was missing it. Elder Health must also amend its long-term contract addenda to include a provision to require the pharmacy to provide price differential information to Part D plans for inclusion in the written Explanation of Benefits. ElderHealth must provide a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Closed
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	Elder Health must revise its policies and procedures to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices. Also Elder Health must revise its policies and procedures to include a provision stating that if the network or preferred pharmacy is on-site, it must deliver the notice described to the location in the LTC facility designated to accept such notices. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that demonstrates it has developed and implemented procedures to conduct ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception and more specifically that Elder Health's network pharmacies meet the requirement for posting or distributing notices. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	Elder Health must revise its policies and procedures to include provisions: - for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits and cost-sharing, and - for tracking and addressing all request for redeterminations. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must notify enrollees of its decision regarding standard coverage determinations concerning benefits within the CMS-approved timeframe, and provide documentation of this to CMS. In cases where Elder Health fails to notify the enrollee of its decision on a coverage determination concerning drug benefit within the required timeframe, Elder Health must forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	Elder Health must revise its policies and procedures to include provisions stating that: - Elder Health must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician¿s supporting statement, - Elder Health must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician¿s supporting statement, and - Elder Health must make payment (i.e. mail the payment) within 30 calendar days of the request, or, for an exception request, after receiving the physician's supporting statements. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must notify enrollees of its decision regarding standard coverage determinations concerning payments within the CMS-approved timeframes, and provide documentation of this to CMS.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Elder Health must notify enrollees of an adverse coverage determination decision using a notice consistent with CMS-issued notice `Notice of Denial of Medicare Prescription Drug Coverage', and provide documentation of this to CMS. Elder Health must conduct training of appropriate staff on the use of the appropriate notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination; The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Elder Health must revise its policies and procedures to include: - a provision for discussing the means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, - provisions stating the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations, and - a means for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must revise its policies and procedures to include a provision stating that Elder Health must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	Elder Health must revise its policies and procedures to include a provision stating that if the decision is adverse, then Elder Health must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. Elder Health must revise its policies and procedures to include a provision stating that if oral notice is provided for an adverse decision, the notice must satisfy the following requirements: -state the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities and special language requirements, if any, -provide information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and -provide a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Elder Health must revise its policies and procedures to include a provision stating that: - if E lder Health requires a written statement from the enrollee's prescribing physician, it must do so immediately, - if Elder Health makes a request for additional supporting medical documentation, Elder Health must clearly identify the type of information that must be submitted, - Elder Health must not keep the exception request open indefinitely when a physician does not submit a supporting statement, - if Elder Health is waiting on a physician's statement in support of a tiering exception request, Elder Health must wait a minimum 96 hours after receiving a standard request or a minimum or 48 hours after receiving an expedited request before issuing its determination on the tiering exception, and - Elder Health must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	Elder Health must revise its policies and procedures to include a provision stating: - if Elder Health makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - Elder Health must not keep the exceptions request open indefinitely when a physician does not submit a supporting statement, and - if Elder Health is waiting on a physician's statement in support of a formulary exception request, Elder Health must wait a minimum of 96 hours after receiving a standard request or a minimum or 48 hours after receiving an expedited request before issuing its determination on the formulary exception. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	Elder Health must revise its policies and procedures to include a provision stating that all approved non-formulary drugs must be placed in existing cost-sharing tier(s). Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that Elder Health places all approved non-formulary drugs into existing cost-sharing tier(s). Elder Health must provide documentation to CMS that Elder Health provides coverage for approved tiering exceptions at the same cost-sharing level as preferred drugs.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	Elder Health must revise its policies and procedures to include provisions for promptly and correctly categorizing complaints as inquiries, grievances or coverage determinations/appeals. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that it has developed and implemented a means of informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees about inquiries involving excluded drugs (consistent with the CMS-issued model notice `Notice of Inquiry Regarding an Excluded Drug'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. E lder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	Elder Health must revise its policies and procedures to include: - provisions for transmitting grievances to appropriate decision-making levels when appropriate and in a timely fashion, - a provision requiring prompt, appropriate action, including a full investigation of the complaint if necessary, -provisions for tracking and maintaining, at a minimum, the date of receipt, disposition of the grievance and the date that the enrollee was notified of the disposition, and - provisions for quarterly reporting of all data requested in Part D Reporting Requirements Section V: Grievances. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. In addition, Elder Health must develop and implement a system for logging or capturing enrollees' grievances in a centralized location and for tracking and maintaining, at a minimum, the following information, and provide documentation of this to CMS: - Receipt date, - Mode of receipt (e.g., fax, telephone, letter, etc.), - Person or entity that filed the grievance, - Subject of the grievance, - Disposition of the grievance, and - Date Elder Health notified the enrollee of the disposition.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	Elder Health must develop policies and procedures to include a provision for training relevant staff and contractors on grievance policies and procedures. Elder Health must conduct training of appropriate staff to ensure they are aware of this addition to the policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	Elder Health must revise its policies and procedures to include provisions stating that: - all concerned parties must be notified of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 days after ElderHealth receives the oral or written grievance, - the 30-day timeframe for processing a grievance may be extended by 14 days or less if the enrollee requests the extension or if Elder Health justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - enrollees must immediately be notified in writing when Elder Health extends the deadline for processing a grievance. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with documentation that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	Elder Health must use a CMS-approved notice consistent with the CMS-issued model notice 'Notice of Plan's Decision Regarding a Grievance' when notifying enrollees in writing of grievance disposition and provide documentation that demonstrates this to CMS. Elder Health must provide documentation to CMS demonstrating the means by which Elder Health responds to standard grievances. Elder Health must conduct training of appropriate staff on the use of the appropriate notice and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	Elder Health must provide documentation to CMS that demonstrates it has developed and implemented procedures for cooperating with QIOs to resolve complaints related to quality of care. Elder Health must conduct training of appropriate staff on these procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	Elder Health must revise its policies and procedures to include a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by Elder Health to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	Elder Health must revise its policies and procedures to include a provision to provide a reasonable opportunity to receive evidence and allegations of law and fact, in person or in writing, related to the disputed issue. Elder Health must provide CMS with documentation demonstrating its system for accepting requests for standard redeterminations which documents the ability to accept written request from the enrollee for a redetermination within the 60 calendar day timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	Elder Health must revise its policies and procedures to include: - a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, - the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and that they may include a facsimile number to facilitate receipt of requests for expedited appeals, and - a provision for documenting all oral requests in writing. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	Elder Health must revise its policies and procedures to include a provision stating that any additional medical information that Elder Health requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination.	Closed

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must revise its policies and procedures to include provisions: - for effectuating the favorable redetermination concerning drug benefit as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination requiring Elder Health to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - stating that Elder Health must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must revise its policies and procedures to: - state that for a redetermination favorable to the enrollee, Elder Health must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination, - include a provision stating that the failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Elder Health to forward the enrollee's complete file to the IRE within 24 hours of the expiration of the adjudication timeframe, and - include a provision stating that Elder Health must inform the enrollee within 24 hours, when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	Elder Health must revise its policies and procedures to include provisions: - indicating that notification of a favorable decision may be made orally or in writing, - stating that medical information must be requested within 24 hours of the enrollee's initial request, - stating that failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring Elder Health to forward the enrollee's request to the IRE within 24 hrs of the expiration of the adjudication timeframe, and - stating that Elder Health must inform the enrollee, within 24 hours when the case is forwarded to the IRE. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of an adverse redetermination (consistent with CMS-issued model notice 'Notice of Redetermination'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must provide CMS with a CMS-approved notice template to inform enrollees of their right to request a reconsideration (consistent with CMS-issued model notice 'Request for Reconsideration'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	Elder Health must revise its policies and procedures to include a provision for authorizing and providing the benefit in dispute within the 72 hour timeframe. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS that it has developed and implemented a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination, and more specifically that Elder Health has a system for expedited coverage determination reversals. Elder Health must provide documentation to CMS that it provides timely notification of expedited redetermination decisions.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	Elder Health must revise its policies and procedures to include a provision stating that a person or persons who were not involved in making the coverage determination conducts the redetermination. Elder Health must revise its policies and procedures to include a provision stating that if the issue is a denial based on lack of medical necessity, then Elder Health must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that Elder Health uses appropriate personnel to conduct redeterminations. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	Elder Health must revise its policies and procedures to include a provision stating that: - case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file, and - a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at is designated fax number. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide documentation to CMS demonstrating that Elder Health forwards untimely cases to the IRE. Elder Health must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Elder Health is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Elder Health must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided within 72 hours from the date it receives notice reversing the decision, and - include a provision requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice `Notice of Effectuation to Part D Independent Review Entity'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Elder Health must revise its policies and procedures to include provisions: - stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision, - stating that payment must be made no later than 30 days from the date it receives notice reversing the decision, and - requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice `Notice of Effectuation to Part D Independent Review Entity'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open

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Bravo Health, Inc.	1-410-864-4437	S5822	Part D	Audit Findings	5/23/2007	Open	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	Elder Health must revise its policies and procedures to: - state that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision, and - include a provision requiring a notice to be sent informing the IRE of the effectuation. Elder Health must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained. Elder Health must provide CMS with a CMS-approved notice template for notifying the IRE of effectuation of decision (consistent with CMS-issued model notice `Notice of Effectuation to Part D Independent Review Entity'). If Elder Health does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. Elder Health must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Open
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	HealthSpring must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	HealthSpring must revise its policies and procedures to include the following provisions: - to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change, and - to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must include an effective date of change on every EOB in order to meet CMS requirements.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	HealthSpring must revise its policies and procedures to contain the following provisions: - a provision for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, - a provision with a description of the procedures for providing a notice of 'maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of 'other' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	HealthSpring must revise its Transition Process policies and procedures to include requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and to include a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must develop a system to track and provide reports regarding HealthSpring's transition process utilization for LTC residents. This documentation must demonstrate to CMS that HealthSpring correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements, as well as the ability to document that HealthSpring has and implements a transition process that covers an emergency supply or 'first fill' of non-formulary Part D drugs.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	HealthSpring must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. HealthSpring must demonstrate that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	HealthSpring must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to include a provision for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. HealthSpring also must revise its policies and procedures to include a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee's appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that the Sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	HealthSpring must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) HealthSpring must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, (2) HealthSpring must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (3) and HealthSpring must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. HealthSpring must ensure that all enrollees are provided with written notification of its decision regarding standard coverage determinations concerning payment within the CMS approved timeframe. If HealthSpring fails to make the coverage determination within the CMS-approved timeframe, it must ensure that it forwards the request to the IRE within the CMS-approved timeframe and timely notifies the enrollee that his or her request has been forwarded. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	HealthSpring must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party). HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of the audit. HealthSpring must ensure that enrollees are provided with a denial notice, when appropriate, and that this is documented. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HealthSpring must revise its policies and procedures to discuss means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, and state that it must grant a request for an expedited determination if it determines, based on the enrollee's request, or as indicated in the prescribing physician's request that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. HealthSpring must revise its policies and procedures to include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations. HealthSpring must revise its policies and procedures to include a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	HealthSpring must revise its policies and procedures to include the following provisions for handling a denied request for an expedited coverage determination: automatically transferring the request to the standard coverage determination process and giving the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently delivering (i.e., mailing) to the enrollee, within 3 calendar days, written notice. HealthSpring must document the request for additional information from the enrollee's physician when denying a coverage determination based on the lack of supporting medical information. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	HealthSpring must revise its policies and procedures to include the following provisions: oral and written notice must provide an explanation that HealthSpring must process the request using the 72 hour timeframe for standard determinations, oral and written notice must inform the enrollee of the right to file an expedited grievance, oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and oral and written notice must provide instructions about HealthSpring's grievance process and its timeframes. HealthSpring must provide CMS with a CMS-approved notice, Notice of Right to an Expedited Grievance. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that if a decision is adverse and HealthSpring first notifies the enrollee of the determination orally, HealthSpring must mail written confirmation to the enrollee within 3 calendar days of the oral notification. HealthSpring must revise its policies and procedures include a provision to inform the enrollee, within 24 hours, when his or her case is forwarded to the IRE. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	HealthSpring must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. HealthSpring must revise its policies and procedures to include a provision stating that if oral notice is provided for the adverse decision, the notice must satisfy the following requirements: states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must demonstrate to CMS that it uses the correct notice when an enrollee's request is denied.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must develop policies and procedures regarding processing requests to its tiered cost-sharing structure that contain the required provisions. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must revise its policies and procedures to include the required provisions regarding processing requests for exceptions for non-formulary drugs. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	HealthSpring must revise its policies and procedures to include provisions stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and all approved non-formulary drugs must be placed in existing cost-sharing tier(s). HealthSpring must provide documentation to CMS that it places all approved non-formulary drugs in existing cost-sharing tiers, in order to demonstrate compliance with this CMS-requirement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	HealthSpring must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must document and notify enrollees of whether their complaint is subject to grievance or coverage determination processes, per CMS requirements. HealthSpring must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	HealthSpring must revise its policies and procedures to ensure they include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. HealthSpring must revise its grievance tracking system to ensure that it captures and maintains the minimum information required: date of receipt of the grievance, mode of receipt of grievance, person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and the date the enrollee was notified of the disposition, and provide CMS with documentation to demonstrate this. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	HealthSpring must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances. HealthSpring must resolve enrollee grievances and do so within the timeframes specified by CMS.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	HealthSpring must ensure it responds to enrollee grievances in accordance with CMS requirements and provide documentation of this to CMS.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	HealthSpring must revise its policies and procedures to include provisions for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must demonstrate that it uses the correct notices when an enrollee's request is denied.	Closed

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HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision that indicates that notification of a favorable decision may be made orally or in writing. HealthSpring must document that it notifies enrollees of the expedited redetermination decision and request for medication information within the approved CMS timeframes, and provide this documentation to CMS. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H1415	MA-PD	Audit Findings	5/23/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	HealthSpring must provide documentation to CMS that demonstrates that it uses appropriate personnel to conduct redeterminations. HealthSpring must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, HealthSpring must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician. CMS may request additional sample cases to determine that HealthSpring is in compliance with this requirement.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.	Universal Health Plan must follow their own disenrollment policy and procedure (DER-4) which states that a copy of the request for disenrollment and a disenrollment letter will be provided to the beneficiary within seven days of receipt of the request to disenroll. Universal Health Plan must provide training to the appropriate staff on this procedure and submit training material and attendance log to the Atlanta regional office. The training must be completed and the information sent to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Refund of Premium - The MAO must refund all amounts incorrectly collected from its Medicare members or from others on their behalf.	Universal Health Plan must adhere to their policy and procedure DER 11 and ensure that members are refunded any premiums collected incorrectly. Universal Health Plan must review each sample case and provide evidence to CMS that a refund was sent to the member. This information must be sent to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Involuntary Disenrollment for Move Out of Service Area - The MAO must disenroll Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than six (6) months, unless they move into an approved plan continuation area and the member has elected the continuation of enrollment option. Member notice is required prior to transmission of the disenrollment to CMS.	Universal Health Plan (UHC) must conduct training to appropriate staff on their own internal policies and procedures (DER 8 and DER 14) which stipulates how to correctly identify voluntary and involuntary disenrollments. UHC must submit documentation to the regional office that details the nature of the training, including the materials used, the individuals conducting the training, and the individuals being trained. This information is due to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Receipt - Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.	UHC must revise its current policies and procedures to ensure that the Enrollment Election Receipt-Dated Elections are appropriately dated as of the date they are received by the MAO. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.	UHC must revise its current policies and procedures to ensure that this element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS.	UHC must revise its current policies and procedures to ensure that the Enrollment Acknowledgement(timeliness) element is accurately depicted. UHC must modify it's current practices to make certain that it notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Notice Content) - The written acknowledgement notice, sent in response to the beneficiary's enrollment election, meets CMS requirements and specifies the correct effective date of enrollment.	UHC must revise its "Notice to Acknowledge Receipt of Completed Enrollment Election" and revise its current policies and procedures to ensure that the Enrollment Acknowledgement (Notice Content) element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	UHC must revise its current policies and procedures to ensure that this element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Submission of Enrollment Transactions to CMS - The MAO follows CMS guidelines for submitting enrollment transactions to CMS.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe is the complete list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Retroactive Enrollment Requests - The MAO requests retroactive enrollments when required, due to CMS enrollment rejection error, and adheres to CMS requirements in requesting retroactive enrollments from the Regional Office or Program Safeguard Contractor.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe is the complete list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Appropriate Follow-Up on Changes in State and County Code - The MAO reviews the CMS Monthly Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follows-up on any change in residence for its members reported to it by CMS.	UHC must revise its current policies and procedures to ensure compliance with this element.UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO must provide to CMS a written plan on how it will provide oversight of the 13 FMOs and its brokers. The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The MAO must provide training to all of its marketing representatives and this training must be documented in their personnel files. The MAO must investigate all marketing complaints on their inquiry log and provide CMS with their resolution. The MAO's management must provide assurances to CMS that they will provide oversight of their marketing staff to ensure future compliance in this area. The MAO must provide to CMS, for the next 12 months, a report of all marketing allegations they receive directly and through CTM with the results of their investigations and the resolutions. All requested documentation and the first report are due to the Regional Office by the end of April 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.	UHC must implement the following: 1. Construct a process which will provide for the development of accurate HSD tables. CMS recommends including subject matter experts from various departments within the agency in this process. Suggeted participants/departments include but are not limited to: a. Clinical staff from UM and Quality Management b. MIS c. Provider Relations 2. Provide to CMS the policies, procedures, and guidelines for the following: a. Accessibility and Availability guidelines for urban and rural network development. b. Strategies for network development and payment when specialists are available but refuse to contract with the Medicare Advantage Organization. c. Guidelines for analyzing the population for geographical penetration of Medicare eligibles, provider panels, and high referral specialists related to provider and population needs. These should also be based on local practice patterns of the population. 3. Create policies and procedures for the development of narratives to explain issues that cannot be addressed on the HSD tables. These include but are not limited to: a. Out of area services based upon practice patterns of the population. b. How services will be made available when providers cannot be contracted within an approved service area. c. Services provided in rural areas outside of CMS access standards, but which are consistent with practice patterns of care. d. Service gaps within a county. 4. Create internal systems which allow for the review of information for accuracy and relevancy before it is sent to CMS. These systems should target but not be limited to, consistency between HSD tables, contract types, and contract signature pages. 5. Submit a sample of HSD tables 1, 2, and 4 which have been created utilizing this new process for building HSD tables to the regional office. These should be submitted to CMS by the end of April 2007. 6. Submit revised HSD 3 tables to the regional office by the end of April 2007. Address whether UHC will seek to obtain contracts for the gaps in the network and specify how enrollees will have access to those services. 7. Submit a quarterly Medicare Provider Network Analysis Reports to the regional office for all counties in the approved service area. The first report will be due to CMS at the end of June 2007. 8. A contingency action plan which addresses: a. Strategies of how the remaining contracted providers will provide inpatient and outpatient services in the network. b. Additional Contracting c. Payment for claims to contracting and non-contracting providers d. Member notification letter addressing how services are to be obtained e. Expected timeframes of completion of each task f. How the MAO will transition:	Closed

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									(1) Members who have prior authorizations and scheduled outpatient procedures with providers who have terminated their contract with UHC. (2) Procedures for members who are currently hospitalized, currently under case management, or receiving specialized service such as dialysis recipients, chemotherapy recipients, and other identified chronically ill members whose providers have terminated their contract with UHC. The action plan should include short and long term goals of how these services will be obtained immediately as well as how UHC is working toward permanently correcting the network issues. Documentation supporting the implementation of the above processes must be submitted to the regional office by the end of April 2007.	
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	UHC must develop and implement the following: 1. Implement the UM plan and program as outlined in the MAO's policies and procedures. 2. Develop a process for sharing relevant information with all departments, providers, and committees such as QA, UM, claims, appeals, grievances, and peer review. 3. Develop a committee structure which expands and incorporates members of the relevant departments into the QA, UM, and Peer Review committees. 4. Develop a process to evaluate the current UM reports and add new relevant reports to the Information System. 5. Audit the denial on retrospective review process of claims to identfy the denial of emergent/urgent care. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.	UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's grievance process. 2. A training program for the appeal and grievance staff. Please provide to CMS the training manual, the individuals conducting the training and a list of the individuals trained. 3. An internal audit system designed to evaluate whether or not grievances are resolved within the timeframes specified in the organization's policies and procedures. 4. A process which requires the appeals/grievance committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must pay the interest on the 2 identified claims were interest was not paid. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and statement of denial reasons for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for favorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. 4. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5429	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the requests for expedited reconsideration process. 2. An internal audit system designed to evaluate whether or not cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.	Universal Health Plan must follow their own disenrollment policy and procedure (DER-4) which states that a copy of the request for disenrollment and a disenrollment letter will be provided to the beneficiary within seven days of receipt of the request to disenroll. Universal Health Plan must provide training to the appropriate staff on this procedure and submit training material and attendance log to the Atlanta regional office. The training must be completed and the information sent to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Refund of Premium - The MAO must refund all amounts incorrectly collected from its Medicare members or from others on their behalf.	Universal Health Plan must adhere to their policy and procedure DER 11 and ensure that members are refunded any premiums collected incorrectly. Universal Health Plan must review each sample case and provide evidence to CMS that a refund was sent to the member. This information must be sent to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Involuntary Disenrollment for Move Out of Service Area - The MAO must disenroll Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than six (6) months, unless they move into an approved plan continuation area and the member has elected the continuation of enrollment option. Member notice is required prior to transmission of the disenrollment to CMS.	Universal Health Plan (UHC) must conduct training to appropriate staff on their own internal policies and procedures (DER 8 and DER 14) which stipulate how to correctly identify voluntary and involuntary disenrollments. UHC must submit documentation to the regional office that details the nature of the training, including the materials used, the individuals conducting the training, and the individuals being trained. This information is due to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Receipt - Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.	UHC must revise its current policies and procedures to ensure that the Enrollment Election Receipt-Dated Elections are appropriately dated as of the date they are received by the MAO. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.	UHC must revise its current policies and procedures to ensure that this element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS.	UHC must revise its current policies and procedures to ensure that the Enrollment Acknowledgement(timeliness) element is accurately depicted. UHC must modify it's current practices to make certain that it notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Notice Content) - The written acknowledgement notice, sent in response to the beneficiary's enrollment election, meets CMS requirements and specifies the correct effective date of enrollment.	UHC must revise its "Notice to Acknowledge Receipt of Completed Enrollment Election" and revise its current policies and procedures to ensure that the Enrollment Acknowledgement (Notice Content) element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	UHC must revise its current policies and procedures to ensure that this element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Submission of Enrollment Transactions to CMS - The MAO follows CMS guidelines for submitting enrollment transactions to CMS.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Retroactive Enrollment Requests - The MAO requests retroactive enrollments when required, due to CMS enrollment rejection error, and adheres to CMS requirements in requesting retroactive enrollments from the Regional Office or Program Safeguard Contractor.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Appropriate Follow-Up on Changes in State and County Code - The MAO reviews the CMS Monthly Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follows-up on any change in residence for its members reported to it by CMS.	UHC must revise its current policies and procedures to ensure compliance with this element.UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO must provide to CMS a written plan on how it will provide oversight of the 13 FMOs and its brokers. The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The MAO must provide training to all of its marketing representatives and this training must be documented in their personnel files. The MAO must investigate all marketing complaints on their inquiry log and provide CMS with their resolution. The MAO's management must provide assurances to CMS that they will provide oversight of their marketing staff to ensure future compliance in this area. The MAO must provide to CMS, for the next 12 months, a report of all marketing allegations they receive directly and through CTM with the results of their investigations and the resolutions. All requested documentation and the first report are due to the Regional Office by the end of April 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's grievance process. 2. A training program for the appeal and grievance staff. Please provide to CMS the training manual, the individuals conducting the training and a list of the individuals trained. 3. An internal audit system designed to evaluate whether or not grievances are resolved within the timeframes specified in the organization's policies and procedures. 4. A process which requires the appeals/grievance committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must pay the interest on the 2 identified claims were interest was not paid. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for favorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. 4. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the favorable standard pre-service reconsideration process. 2. An internal audit system designed to evaluate whether or not overturns are authorized within the timeframes in the organization's policies and procedures. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the unfavorable standard pre-service reconsideration process. 2. An internal audit system designed to evaluate whether or not denied cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5820	MA	Audit Findings	5/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the requests for expedited reconsideration process. 2. An internal audit system designed to evaluate whether or not cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
EmblemHealth Inc.	1-646-447-6200	H3330	MA-PD	Audit Findings	5/14/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	The organization must offer uniform LTC beneficiary protections.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
EmblemHealth Inc.	1-646-447-6200	S5741	Part D	Audit Findings	5/14/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	The MAO must submit a revised notice to CMS for approval that includes the required information.	Closed
EmblemHealth Inc.	1-646-447-6200	S5741	Part D	Audit Findings	5/14/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	The organization must offer uniform LTC beneficiary protections.	Closed
HIP, Health Plan of New York		H3345 (Withdrawn Contract)	MA	Audit Findings	5/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	MAO must submit another univere and another sample of cases will be selected by CMS reviewer. MAO will submit selected cases and documentation to the Regional Office for a desk review to occur.	Closed
HIP, Health Plan of New York		H3345 (Withdrawn Contract)	MA	Audit Findings	5/14/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	MAO must submit another univere and another sample of cases will be selected by CMS reviewer. MAO will submit selected cases and documentation to the Regional Office for a desk review to occur.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	BCBSM must provide CMS with evidence that marketing program monitoring activities confirm that BCBSM's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. BCBSM must also provide CMS with evidence that it has a current contract/ compensation structure in effect that includes the following provisions: - Any person directly employed or contracted to market on behalf of BCBSM must provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with BCBSM. The person may be compensated based on your enrollment in a plan.¿ - Any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal health care laws (including civil monetary penalty laws). BCBSM must also provide CMS with evidence that it has a current employee-specific contract/compensation structure in effect that demonstrates that an actual contractual/ employment relationship exists between BCBSM and its employees, and demonstrates or includes the above provisions as well as those listed below: - A compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans. - A person/agency performing marketing to beneficiaries is prohibited from making payments to beneficiaries. - Payment will be withheld or withdrawn if an enrollee disenrolls in an unreasonably short time frame.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	BCBSM must revise its policies and procedures to include the following provisions: - to notify affected enrollees in writing at least 60 days prior to the date of formulary changes, - stating that if no prior notice is given, to ensure that affected enrollees are provided with a 60-day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and -stating that members will be notified of `maintenance' and `other' formulary changes. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide documentation to CMS that the notice regarding formulary changes notifies affected enrollees at least 60 days prior to the date of change and the notice must contain an effective date to meet CMS requirements.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	Blue Cross Blue Shield of Michigan must revise its policies and procedures to include the following provisions: - providing a notice of 'maintenance' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, - providing a notice of 'other' formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, and - providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	BCBSM must update its policies and procedures (Part D Std Coverage Determinations.pdf) to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. BCBSM must instruct the LTC facility staff to provide the enrollee (or the enrollee's appointed representative) and the enrollee's treating physician with the notice, and to place a copy of the notice in the enrollee's file at the LTC facility. BCBSM must submit to CMS a template contract for its network I/T/U pharmacies that contains a provision requiring I/T/U pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception. BCBSM must provide CMS with documentation that demonstrates that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone an audit.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	BCBSM must revise its policies and procedures to include provisions for consistently tracking and addressing in a timely manner oral and written requests for both standard and expedited redeterminations. BCBSM must revise the system it uses to track and address, in a timely manner, enrollees' oral and written requests for exceptions, coverage determinations, and redeterminations to ensure that it correctly documents the date that requests are received by BCBSM, the disposition of the request, the date of disposition, and the date the beneficiary is notified of the disposition of the request, and provide documentation of this to CMS. BCBSM must conduct training of appropriate staff on policies and procedures and its systems for tracking, addressing, and maintaining documentation on the timely review and resolution of all enrollee requests for exceptions, coverage determinations, and redeterminations. BCBSM must submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures to include a provision stating that failure to notify the enrollee of its coverage determination concerning drug benefits decision within the required timeframe constitutes an adverse coverage determination requiring BCBSM to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for enrollee notification when a request for coverage determination concerning drug benefit is forwarded to the IRE because the notice of coverage determination decision is not made timely. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must notify enrollees of its decision regarding standard coverage determinations concerning benefits within the CMS-approved timeframe.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	BCBSM must revise its policies and procedures to include provisions stating: - that if it makes a favorable decision on a coverage determination concerning payment, it must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - that when BCBSM makes a favorable decision on a coverage determination concerning payment, it must make the payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and - that failure to notify the enrollee of its decision on a coverage determination concerning payment within the required timeframe constitutes an adverse coverage determination requiring it to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for enrollee notification when a request for coverage determination concerning payment is forwarded to the IRE because the notice of coverage determination decision is not made timely. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Requests for Coverage Determination Concerning Payment, contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	Blue Cross Blue Shield of Michigan must provide CMS with a CMS-approved notice template for notifying enrollees of an adverse coverage determination, whether in part or whole. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must notify enrollees of an adverse coverage determination decision using a CMS-approved notice template, and provide documentation of this to CMS. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	BCBSM must revise its policies and procedures (Part D Std Coverage Determination.pdf and Coverage Determinations/Exceptions.pdf (Policy #CE01)) to include the criteria BCBSM uses for issuing prompt decisions regarding requests for expedited coverage determinations from physicians and members. These criteria, at a minimum, must state that a request for an expedited coverage determination must be granted if BCBSM determines, based on the enrollee's request, or as indicated in the prescribing physician's request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. BCBSM must also develop and implement written policies and procedures for making decisions on expediting a coverage determination within the appropriate timeframe for requests from its members that are received outside of normal business hours. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	BCBSM must develop and implement policies and procedures regarding enrollee notification following a decision to deny a request for an expedited coverage determination. These procedures must include provisions stating that if BCBSM denies a request to expedite a coverage determination, it must automatically transfer the request to the standard coverage determination process, give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	BCBSM must develop and implement policies and procedures regarding enrollee notification following a decision to deny a request for an expedited coverage determination that include provisions stating: - that oral and written notice must provide an explanation that BCBSM must process the request using the 72 hour timeframe for standard determinations, - that oral and written notice must inform the enrollee of the right to file an expedited grievance, - that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physicians support, and - that oral and written notice must provide instructions about BCBSM's grievance process and its timeframes. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for notifying an enrollee that a request for an expedited coverage determination is denied. This notice must be consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance.' If BCBSM does not have a template for this notice that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must also conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures to include the following provisions: - that BCBSM must make an expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement, - that if a decision on an expedited coverage determination is adverse and BCBSM first notifies the enrollee of the determination orally, it must mail written confirmation to the enrollee within 3 calendar days of the oral notification, - that failure to notify the enrollee of its decision on an expedited coverage determination within the required timeframe constitutes an adverse coverage determination, requiring BCBSM to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe, and - that BCBSM must inform the enrollee, within 24 hours, when the case is forwarded to the IRE because it failed to provide timely notice of a decision on an expedited coverage determination. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for enrollee notification when a request for expedited coverage determination is forwarded to the IRE because the notice of expedited coverage determination decision is not made timely. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	BCBSM must develop and implement policies and procedures that include a provision stating that if oral notice is provided for an adverse decision on an expedited coverage determination, the notice must satisfy the following requirements: - states the specific reason for the denial and takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for notifying enrollees of an adverse expedited coverage determination. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	BCBSM must develop and implement policies and procedures that include the following provisions stating that: - if BCBSM makes a request for additional supporting medical documentation from a prescribing physician, to support a request for a tiering exception, then it must clearly identify the type of information that must be submitted. - BCBSM must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	BCBSM must develop and implement policies and procedures that include the following provisions: - stating that an enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception, - stating that if BCBSM makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - stating BCBSM must grant a formulary exception when it determines that one of the three factors listed below has been demonstrated, and the drug would be covered but for the fact that it is a off-formulary drug (or more specifically given BCBSM's open formulary, a drug subject to utilization tools). (1) All covered Part D drugs on any tier of BCBSM's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, or (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	BCBSM must update its Coverage Determinations/Exceptions.pdf (Policy #CE01), and any other applicable policies that specifically address non-formulary exceptions, to include a provision stating that its enrollees are not required to request an approval for a refill or a new prescription following the initial prescription for, at a minimum, the remainder of the plan year. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must be able to demonstrate, and provide documentation of this to CMS, that it provides coverage for approved tiering exceptions at the same cost-sharing level as preferred drugs. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Requests for Coverage Determination Concerning Payments, contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	BCBSM must revise its grievance policies and procedures (GV01_Categorizing of Complaints.pdf, GV01PandP_GA07 - Part D Complaints.pdf) as follows: -include a definition of 'Inquiry' and a correct definition of 'Appeals,' -replace all current incorrect references to 'Appeals' with 'Coverage Determinations,' -include policies and procedures to inform enrollees whether their complaints are subject to grievance or coverage determination procedures, and -demonstrate that it has a means of informing enrollees of complaint categorization (e.g., phone script and notice template). BCBSM must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must demonstrate and provide documentation to CMS that it has a means of informing enrollees of complaint categorizatin (e.g., phone scripts and notice template). BCBSM must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'). If BCBSM does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, 'Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universes submitted for WS-GV1_D, Standard Grievances, and WS-CD2_D, Requests for Coverage Determination Concerning Payment, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	BCBSM must revise its policies and procedures to include the following provisions: - tracking and maintaining, at a minimum, the date of receipt, disposition of the grievance, and the date that the enrollee was notified of the disposition, and - quarterly reporting of all data requested in Part D Reporting Requirements Section V: Grievances. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Finally, BCBSM must include and use the following columns in its Excel Tracking Log: 'Mode of Receipt of Grievance', 'Subject of the Grievance', and 'Date the Enrollee was Notified of the Disposition.' BCBSM must conduct training of appropriate staff on the use of the Excel Tracking Log and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	BCBSM must revise its policies and procedures to include a provision for training relevant staff on grievance policies and procedures. In addition, BCBSM must provide CMS with documentation that demonstrates that it has and implements a formal training program regarding its grievance policies and procedures. BCBSM must conduct training of appropriate staff to ensure they are aware of this addition to the policies and procedures, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	BCBSM must revise its policies and procedures to include the following provisions: - the 30-day timeframe for processing a grievance may be extended by 14 days or less if the enrollee requests the extension or if BCBSM justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - the enrollee must immediately be notified in writing when BCBSM extends the deadline for processing a grievance. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for informing enrollees of a grievance deadline extension. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D, Standard Grievances, contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	BCBSM must revise its policies and procedures to include the following provisions: - all grievances submitted in writing must be responded to in writing, and - grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for enrollee notification of grievance disposition. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-GV1_D contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	BCBSM must revise its policies and procedures to include the following provisions: - all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing, and - BCBSM is committed to cooperating with the QIO in resolving quality of care grievance cases. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for enrollee notification of grievance disposition. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	BCBSM must revise its Excel Tracking Log to include columns that BCBSM can use to clearly track whether or not written requests for redeterminations are made and accepted within the 60 calendar day timeframe (i.e., 60 days from the date of initial determination), and provide documentation of this to CMS. BCBSM must conduct training of appropriate staff on the use of these columns and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, and WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause(s) as well as detailed corrective action plans to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	BCBSM must revise its policies and procedures for expedited redeterminations (RE02_RE03_RE04_RE07_RE09_RE10_PR05 - Expedited Redetermination.pdf) to include the provisions stating the name of a designated office and/or department to receive both oral or written requests for expedited redeterminations, and a telephone number for oral requests for expedited redeterminations. In addition, BCBSM must revise its policies and procedures for redeterminations (CD02_GA09 - Part D Appeals Policy.pdf) to include a phone number for both oral and written requests. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	BCBSM must provide CMS with a CMS-approved notice template for notifying an enrollee that a request for an expedited redetermination is denied. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures to include provisions: - for effectuating a favorable redetermination, concerning drug benefit, as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and - stating that BCBSM must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. In addition, BCBSM must add 'within 24 hours' to the appropriate portion of the provision included in 'CD02_GA09 - Part D Appeals Policy.pdf.' BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with CMS-approved notice templates for: - notifying enrollees of an adverse standard redetermination, - requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), and - notifying enrollee when a request for standard redetermination concerning drug benefit is forwarded to the IRE because the notice of redetermination decision is not made timely If BCBSM does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures (RE05_RE06_RV01_RV02_RV03_PR15 - Case Effectuation.pdf and CD02_GA09 - Part D Appeals Policy.pdf) to include a provision stating that for favorable redeterminations concerning payment, BCBSM must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. BCBSM must add the entire provision to 'RE05_RE06_RV01_RV02_RV03_PR15 - Case Effectuation.pdf.' In addition, BCBSM must replace the statement `from date of receipt of the notice reversing the Plan determination' with `from the date it received the request for a standard redetermination' in the appropriate portion of the provision included in 'CD02_GA09 - Part D Appeals Policy.pdf. BCBSM must revise its policies and procedures (RE05_RE06_RV01_RV02_RV03_PR15 - Case Effectuation.pdf and CD02_GA09 - Part D Appeals Policy.pdf) to include the provision stating that BCBSM must inform the enrollee 'within 24 hours' when the case is forwarded to the IRE. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with CMS-approved notice templates for: - notifying enrollees of an adverse standard redetermination, - requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), and - notifying enrollee when a request for standard redetermination concerning payment is forwarded to the IRE because the notice of redetermination decision is not made timely If BCBSM does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures to include a provision stating that BCBSM must inform the enrollee, within 24 hours, when the case is forwarded to the IRE due to BCBSM's failure to notify the enrollee of its decision within the required timeframe. Specifically, BCBSM must add the entire provision to 'RE02_RE03_RE04_RE07_RE09_RE10_PR05 - Expedited Redetermination.pdf' and add 'within 24 hours' to the appropriate portion of the provision included in 'CD02_GA09 - Part D Appeals Policy.pdf.' BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with CMS-approved notice templates for: - notifying enrollees of an adverse expedited redetermination, - requesting a reconsideration (i.e., a notice consistent with the CMS-issued model notice, 'Request for Reconsideration'), and - notifying enrollees when a request for expedited redetermination is forwarded to the IRE because the notice of redetermination decision is not made timely. If BCBSM does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	BCBSM must revise its policies and procedures to include a provision for authorizing or providing the benefits in dispute within the 72-hour required timeframe if, on an expedited redetermination of a request for benefit, BCBSM reverses, in whole or in part, its coverage determination. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must develop, implement, and provide documentation to CMS that it has a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination if the expedited redetermination results in a reversal. BCBSM must conduct training of appropriate staff on the existence and use of these systems and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	BCBSM must revise its policies and procedures to include a provision that requires a person or persons who were not involved in making the initial coverage determination to conduct the redetermination. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, and WS-RE2_D, Requests for Standard Redeterminations Concerning Payment, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	BCBSM must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, and WS-RE2_D, Requests for Standard Redeterminations Concerning Payment, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	BCBSM must provide CMS with a CMS-approved notice template for notifying the IRE of its effectuation of a decision reversing a determination on a request for drug benefit. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	BCBSM must provide CMS with a CMS-approved notice template for notifying the IRE of its effectuation of a decision reversing a determination on a request for payment. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D, Requests for Standard Redeterminations Concerning Payment, contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	H2319	MA-PD	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	BCBSM must provide CMS with a CMS-approved notice template for notifying the IRE of its effectuation of a decision reversing an expedited determination or expedited redetermination for drug benefit. If BCBSM does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	BCBSM must provide CMS with evidence that marketing program monitoring activities confirm that BCBSM's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. BCBSM must also provide CMS with evidence that it has a current contract/ compensation structure in effect that includes the following provisions: - Any person directly employed or contracted to market on behalf of BCBSM must provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and the written disclosure statement must state the following: `The person that is discussing plan options with you is either employed by or contracted with BCBSM. The person may be compensated based on your enrollment in a plan.¿ - Any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and the prohibited activities listed in MR05, and all Federal health care laws (including civil monetary penalty laws). BCBSM must also provide CMS with evidence that it has a current employee-specific contract/compensation structure in effect that demonstrates that an actual contractual/ employment relationship exists between BCBSM and its employees, and demonstrates or includes the above provisions as well as those listed below: - A compliant incentive structure avoiding incentives toward misleading beneficiaries, cherry picking certain beneficiaries, or churning beneficiaries between plans. - A person/agency performing marketing to beneficiaries is prohibited from making payments to beneficiaries. - Payment will be withheld or withdrawn if an enrollee disenrolls in an unreasonably short time frame.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	BCBSM must revise its policies and procedures to include the following provisions: - to notify affected enrollees in writing at least 60 days prior to the date of formulary changes, - stating that if no prior notice is given, to ensure that affected enrollees are provided with a 60-day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and - stating that members will be notified of 'maintenance' and 'other' formulary changes. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM's EOBs must be dated and contain an effective date of formulary change to meet CMS requirements, and provide documentation of this to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	BCBSM must revise its policies and procedures to include provisions for providing: - a notice of `maintenance' formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, - a notice of `other' formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, and - a retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	BCBSM must update its policies and procedures (Part D Std Coverage Determinations.pdf) to include a provision for sending the `Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. BCBSM must instruct the LTC facility staff to provide the enrollee (or the enrollee's appointed representative) and the enrollee's treating physician with the notice, and to place a copy of the notice in the enrollee's file at the LTC facility. BCBSM must submit to CMS a template contract for its network I/T/U pharmacies that contains a provision requiring I/T/U pharmacies to post or distribute notices regarding procedures for obtaining a coverage determination or requesting an exception. BCBSM must provide CMS with documentation demonstrating that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone an audit.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	BCBSM must revise its policies and procedures to include provisions for consistently tracking and addressing in a timely manner oral and written requests for both standard and expedited redeterminations. BCBSM must revise the system it uses to track and address, in a timely manner, enrollees' oral and written requests for exceptions, coverage determinations, and redeterminations to ensure that it correctly documents the date that requests are received by BCBSM, the disposition of the request, the date of disposition, and the date the beneficiary is notified of the disposition of the request, and provide documentation of this to CMS. BCBSM must conduct training of appropriate staff on policies and procedures and its systems for tracking, addressing, and maintaining documentation on the timely review and resolution of all enrollee requests for exceptions, coverage determinations, and redeterminations. BCBSM must submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures to include a provision stating that failure to notify the enrollee of its coverage determination concerning drug benefits decision within the required timeframe constitutes an adverse coverage determination requiring BCBSM to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must notify enrollees of its decision regarding standard coverage determinations concerning benefits within the CMS-approved timeframe, and provide documentation of this to CMS.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	BCBSM must revise its policies and procedures to include provisions stating: - that if BCBSM makes a favorable decision on a coverage determination concerning payment, it must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - that when BCBSM makes a favorable decision on a coverage determination concerning payment, it must make the payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement, and - that failure to notify the enrollee of BCBSM's decision on a coverage determination concerning payment within the required timeframe constitutes an adverse coverage determination requiring it to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Requests for Coverage Determination Concerning Payment, contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	BCBSM must notify enrollees of an adverse coverage determination decision using a CMS-approved notice template, and provide documentation of this to CMS. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination; The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	BCBSM must revise its policies and procedures (Part D Std Coverage Determination.pdf and Coverage Determinations/Exceptions.pdf (Policy #CE01)) to include the criteria BCBSM uses for issuing prompt decisions regarding requests for expedited coverage determinations from physicians and members. These criteria, at a minimum, must state that a request for an expedited coverage determination must be granted if BCBSM determines, based on the enrollee's request, or as indicated in the prescribing physician's request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. BCBSM must also develop and implement written policies and procedures for making decisions on expediting a coverage determination within the appropriate timeframe for requests from its members that are received outside of normal business hours. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	BCBSM must develop and implement policies and procedures regarding enrollee notification following a decision to deny a request for an expedited coverage determination. These procedures must include provisions stating that if BCBSM denies a request to expedite a coverage determination, it must automatically transfer the request to the standard coverage determination process, give the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently deliver (i.e., mail) to the enrollee, within 3 calendar days, written notice. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	BCBSM must develop and implement policies and procedures regarding enrollee notification following a decision to deny a request for an expedited coverage determination that include provisions stating: -that oral and written notice must provide an explanation that BCBSM must process the request using the 72 hour timeframe for standard determinations, -that oral and written notice must inform the enrollee of the right to file an expedited grievance, -that oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physicians support, and -that oral and written notice must provide instructions about BCBSM's grievance process and its timeframes. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice template for notifying an enrollee that a request for an expedited coverage determination is denied. This notice must be consistent with the CMS-issued model notice, `Notice of Right to an Expedited Grievance'. If BCBSM does not have a template for this notice that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must also conduct training of appropriate staff on the use of this template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures to include the following provisions: - that BCBSM must make an expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement, - that if a decision on an expedited coverage determination is adverse and BCBSM first notifies the enrollee of the determination orally, it must mail written confirmation to the enrollee within 3 calendar days of the oral notification, - that failure to notify the enrollee of its decision on an expedited coverage determination within the required timeframe constitutes an adverse coverage determination, requiring BCBSM to forward the enrollee's request to the IRE within 24 hours of the expiration of the adjudication timeframe, and - that BCBSM must inform the enrollee, within 24 hours, when the case is forwarded to the IRE because it failed to provide timely notice of a decision on an expedited coverage determination. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	BCBSM must develop and implement policies and procedures that include a provision stating that if oral notice is provided for an adverse decision on an expedited coverage determination, the notice must satisfy the following requirements: - states the specific reason for the denial and takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	BCBSM must develop and implement policies and procedures that include the following provisions stating that: - if BCBSM makes a request for additional supporting medical documentation from a prescribing physician, to support a request for a tiering exception, then it must clearly identify the type of information that must be submitted. - BCBSM must grant a tiering exception when it determines that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	BCBSM must develop and implement policies and procedures that include the following provisions: - stating that an enrollee, an enrollee's appointed representative, or an enrollee's prescribing physician shall be permitted to file a request for a non-formulary exception, - stating that if BCBSM makes a request for additional supporting medical documentation, then it must clearly identify the type of information that must be submitted, - stating BCBSM must grant a formulary exception when it determines that one of the three factors listed below has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug (or more specifically given BCBSM's open formulary, a drug subject to utilization tools). (1) All covered Part D drugs on any tier of BCBSM's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects, or (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance, or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	BCBSM must update its Coverage Determinations/Exceptions.pdf (Policy #CE01), and any other applicable policies that specifically address non-formulary exceptions, to include a provision stating that its enrollees are not required to request an approval for a refill or a new prescription following the initial prescription for, at a minimum, the remainder of the plan year. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D, Requests for Coverage Determination Concerning Payments, contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	BCBSM must revise its grievance policies and procedures (GV01_Categorizing of Complaints.pdf, GV01PandP_GA07 - Part D Complaints.pdf) as follows: -include a definition of 'Inquiry' and a correct definition of 'Appeals,' -replace all current incorrect references to 'Appeals' with 'Coverage Determinations,' and -include policies and procedures to inform enrollees whether their complaints are subject to grievance or coverage determination procedures. BCBSM must provide documentation to CMS that it has a means of informing enrollees of complaint categorization (e.g., phone script and notice template). BCBSM must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'). If BCBSM does not have a notice template that has been approved by CMS (i.e., a notice consistent with the CMS-issued model notice, `Notice of Inquiry Regarding an Excluded Drug'), then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must inform enrollees, and provide CMS with documentation of this notification, of whether their complaint is subject to grievance or coverage determination procedures, per CMS requirements. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-CD2_D contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	BCBSM must revise its policies and procedures to include the following provisions: - tracking and maintaining, at a minimum, the date of receipt, disposition of the grievance, and the date that the enrollee was notified of the disposition, and - quarterly reporting of all data requested in Part D Reporting Requirements Section V: Grievances. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Finally, BCBSM must include and use the following columns in its Excel Tracking Log: 'Mode of Receipt of Grievance', 'Subject of the Grievance', and 'Date the Enrollee was Notified of the Disposition', and provide documentation of this to CMS. BCBSM must conduct training of appropriate staff on the use of the Excel Tracking Log and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	BCBSM must revise its policies and procedures to include a provision for training relevant staff on grievance policies and procedures. In addition, BCBSM must provide CMS with documentation that demonstrates that it has and implements a formal training program regarding its grievance policies and procedures. BCBSM must conduct training of appropriate staff to ensure they are aware of this addition to the policies and procedures, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	BCBSM must revise its policies and procedures to include the following provisions: - the 30-day timeframe for processing a grievance may be extended by 14 days or less if the enrollee requests the extension or if BCBSM justifies a need for additional information and documents how the delay is in the interest of the enrollee, and - the enrollee must immediately be notified in writing when BCBSM extends the deadline for processing a grievance. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must notify enrollees of grievance resolution, and document this notification, within the CMS-approved timeframe, and provide CMS documentation of this.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	BCBSM must revise its policies and procedures to include the following provisions: - all grievances submitted in writing must be responded to in writing, and - grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must document the method it uses to inform the enrollee of his/her grievances resolution, and provide documentation of this to CMS.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	BCBSM must revise its policies and procedures to include the following provisions: - all grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing, and - BCBSM is committed to cooperating with the QIO in resolving quality of care grievance cases. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Standard) - The Part D sponsor must have policies, procedures, and systems in place that allow it to accept written requests for standard redeterminations of coverage determinations filed within 60 calendar days of the notice of the coverage determination. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to hand-deliver or present in writing, evidence and allegations of fact or law related to the issue in dispute.	BCBSM must revise its Excel Tracking Log to include columns that BCBSM can use to clearly track whether or not written requests for redeterminations are made and accepted within the 60 calendar day timeframe (i.e., 60 days from the date of initial determination), and provide documentation of this to CMS. BCBSM must conduct training of appropriate staff on the use of these columns and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, and WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause(s) as well as detailed corrective action plans to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	BCBSM must revise its policies and procedures for expedited redeterminations (RE02_RE03_RE04_RE07_RE09_RE10_PR05 - Expedited Redetermination.pdf) to include the provisions stating the name of a designated office and/or department to receive both oral or written requests for expedited redeterminations, and a telephone number for oral requests for expedited redeterminations. In addition, BCBSM must revise its policies and procedures for redeterminations (CD02_GA09 - Part D Appeals Policy.pdf) to include a phone number for both oral and written requests. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures to include provisions: - for effectuating a favorable redetermination, concerning drug benefit, as expeditiously as the enrollee's health condition requires or within 7 calendar days from the date it received the request for a standard redetermination, and - stating that BCBSM must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. In addition, BCBSM must add `within 24 hours' to the appropriate portion of the provision included in 'CD02_GA09 - Part D Appeals Policy.pdf.' BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with CMS-approved notice templates for a `Notice of Redetermination' and 'Notice for Request for Reconsideration'. If BCBSM does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures (RE05_RE06_RV01_RV02_RV03_PR15 - Case Effectuation.pdf and CD02_GA09 - Part D Appeals Policy.pdf) to include a provision stating that for favorable redeterminations concerning payment, BCBSM must authorize payment within 7 calendar days and make payment within 30 calendar days from the date it received the request for a standard redetermination. BCBSM must add the entire provision to 'RE05_RE06_RV01_RV02_RV03_PR15 - Case Effectuation.pdf.' In addition, BCBSM must replace the statement `from date of receipt of the notice reversing the Plan determination' with `from the date it received the request for a standard redetermination' in the appropriate portion of the provision included in 'CD02_GA09 - Part D Appeals Policy.pdf. BCBSM must revise its policies and procedures (RE05_RE06_RV01_RV02_RV03_PR15 - Case Effectuation.pdf and CD02_GA09 - Part D Appeals Policy.pdf) to include the provision stating that BCBSM must inform the enrollee, `within 24 hours', when the case is forwarded to the IRE. BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with CMS-approved notice templates for notifying enrollees of an adverse standard redetermination and for notifying enrollees about requesting a reconsideration. These notices must be consistent with the CMS-issued model notices, `Notice of Redetermination' and `Notice for Request for Reconsideration.' If BCBSM does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D, Requests for Standard Redeterminations Concerning Payments, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	BCBSM must revise its policies and procedures to include a provision stating that BCBSM must inform the enrollee, within 24 hours, when the case is forwarded to the IRE due to BCBSM's failure to notify the enrollee of its decision within the required timeframe. Specifically, BCBSM must add the entire provision to 'RE02_RE03_RE04_RE07_RE09_RE10_PR05 - Expedited Redetermination.pdf' and add `within 24 hours' to the appropriate portion of the provision included in 'CD02_GA09 - Part D Appeals Policy.pdf.' BCBSM must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with CMS-approved notice templates for notifying enrollees of an adverse standard redetermination and for notifying enrollees about requesting a reconsideration. These notices must be consistent with the CMS-issued model notices, `Notice of Redetermination' and `Notice for Request for Reconsideration'. If BCBSM does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. BCBSM must conduct training of appropriate staff on the use of these templates and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Expedited Coverage Redetermination Reversals - If, on an expedited redetermination of a request for benefit, the Part D sponsor reverses, in whole or in part, its coverage determination, it must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires, but no later than 72 hours after the date the Part D sponsor receives the request for redetermination.	BCBSM must revise its policies and procedures to include a provision for authorizing or providing the benefits in dispute within the 72-hour required timeframe if, on an expedited redetermination of a request for benefit, BCBSM reverses, in whole or in part, its coverage determination. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must develop, implement, and provide documentation to CMS that it has a system for authorizing or providing a benefit under dispute within 72 hours of receiving the request for redetermination if the expedited redetermination results in a reversal. BCBSM must conduct training of appropriate staff on the existence and use of these systems and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	BCBSM must revise its policies and procedures to include a provision that requires a person or persons who were not involved in making the initial coverage determination to conduct the redetermination. BCBSM must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. BCBSM must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, and WS-RE2_D, Requests for Standard Redeterminations Concerning Payment, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed

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Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.	BCBSM must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits, and WS-RE2_D, Requests for Standard Redeterminations Concerning Payment, contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	BCBSM must demonstrate to CMS that it effectuates a decision that has been reversed by the IRE for cases concerning drug benefit within the timeframes required by CMS and notifies the IRE of the effectuation of any reconsideration decision that fully or partially reverses BCBSM's redetermination decision. BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D, Requests for Standard Redeterminations Concerning Drug Benefits contained misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
Blue Cross Blue Shield of Michigan	1-248-350-4475	S5584	Part D	Audit Findings	5/4/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	BCBSM must provide CMS with an analysis and explanation of why the universe submitted for WS-RE2_D, Requests for Standard Redeterminations Concerning Payment, contains misclassified cases. Based on the analysis, BCBSM is to provide to CMS, the root cause as well as a detailed corrective action plan to ensure that this element will be met consistently.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	HealthSpring must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	HealthSpring must revise its policies and procedures to include the following provisions: - to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change, and - to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must include an effective date of change on every EOB in order to meet CMS requirements.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	HealthSpring must revise its policies and procedures to contain the following provisions: - a provision for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, - a provision with a description of the procedures for providing a notice of "maintenance" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of "other" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	HealthSpring must revise its Transition Process policies and procedures to include requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and to include a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must develop a system to track and provide reports regarding HealthSpring's transition process utilization for LTC residents. This documentation must demonstrate to CMS that HealthSpring correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements, as well as the ability to document that HealthSpring has and implements a transition process that covers an emergency supply or "first fill" of non-formulary Part D drugs.	Closed

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HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	HealthSpring must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. HealthSpring must demonstrate that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	HealthSpring must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to include a provision for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. HealthSpring also must revise its policies and procedures to include a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee's appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that the Sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	HealthSpring must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) HealthSpring must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, (2) HealthSpring must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (3) and HealthSpring must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. HealthSpring must ensure that all enrollees are provided with written notification of its decision regarding standard coverage determinations concerning payment within the CMS approved timeframe. If HealthSpring fails to make the coverage determination within the CMS-approved timeframe, it must ensure that it forwards the request to the IRE within the CMS-approved timeframe and timely notifies the enrollee that his or her request has been forwarded. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	HealthSpring must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party). HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of the audit. HealthSpring must ensure that enrollees are provided with a denial notice, when appropriate, and that this is documented. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination; The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HealthSpring must revise its policies and procedures to discuss means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, and state that it must grant a request for an expedited determination if it determines, based on the enrollee's request, or as indicated in the prescribing physician's request that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. HealthSpring must revise its policies and procedures to include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations. HealthSpring must revise its policies and procedures to include a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	HealthSpring must revise its policies and procedures to include the following provisions for handling a denied request for an expedited coverage determination: automatically transferring the request to the standard coverage determination process and giving the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently delivering (i.e., mailing) to the enrollee, within 3 calendar days, written notice. HealthSpring must document the request for additional information from the enrollee's physician when denying a coverage determination based on the lack of supporting medical information. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	HealthSpring must revise its policies and procedures to include the following provisions: oral and written notice must provide an explanation that HealthSpring must process the request using the 72 hour timeframe for standard determinations, oral and written notice must inform the enrollee of the right to file an expedited grievance, oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and oral and written notice must provide instructions about HealthSpring's grievance process and its timeframes. HealthSpring must provide CMS with a CMS-approved notice, Notice of Right to an Expedited Grievance. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that if a decision is adverse and HealthSpring first notifies the enrollee of the determination orally, HealthSpring must mail written confirmation to the enrollee within 3 calendar days of the oral notification. HealthSpring must revise its policies and procedures include a provision to inform the enrollee, within 24 hours, when his or her case is forwarded to the IRE. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	HealthSpring must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. HealthSpring must revise its policies and procedures to include a provision stating that if oral notice is provided for the adverse decision, the notice must satisfy the following requirements: (1) states the specific reason for the denial and takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, (2)provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and (3) provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must demonstrate to CMS that it uses the correct notice when an enrollee's request is denied.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must develop policies and procedures regarding processing requests to its tiered cost-sharing structure that contain the required provisions. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must revise its policies and procedures to include the required provisions regarding processing requests for exceptions for non-formulary drugs. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	HealthSpring must revise its policies and procedures to include provisions stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and all approved non-formulary drugs must be placed in existing cost-sharing tier(s). HealthSpring must provide documentation to CMS that it places all approved non-formulary drugs in existing cost-sharing tiers, in order to demonstrate compliance with this CMS-requirement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	HealthSpring must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must document and notify enrollees of whether their complaint is subject to grievance or coverage determination processes, per CMS requirements. HealthSpring must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	HealthSpring must revise its policies and procedures to ensure they include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. HealthSpring must revise its grievance tracking system to ensure that it captures and maintains the minimum information required: date of receipt of the grievance, mode of receipt of grievance, person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and the date the enrollee was notified of the disposition, and provide CMS with documentation to demonstrate this. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	HealthSpring must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances. HealthSpring must resolve enrollee grievances and do so within the timeframes specified by CMS.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	HealthSpring must revise its policies and procedures to include provisions for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision that indicates that notification of a favorable decision may be made orally or in writing. HealthSpring must document that it notifies enrollees of the expedited redetermination decision and request for medication information within the approved CMS timeframes, and provide this documentation to CMS. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	HealthSpring must provide documentation to CMS that demonstrates that it uses appropriate personnel to conduct redeterminations. HealthSpring must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, HealthSpring must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician. CMS may request additional sample cases to determine that HealthSpring is in compliance with this requirement.	Closed
HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HealthSpring must demonstrate to CMS that it effectuates a decision that has been reversed by the IRE for cases concerning drug benefit within the timeframes required by CMS and must notify the IRE of the effectuation of any reconsideration decision that fully or partially reverses HealthSpring's redetermination decision.	Closed

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HealthSpring, Inc.	1-615-236-6116	S5932	Part D	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HealthSpring must demonstrate to CMS that it effectuates a decision that has been reversed by the IRE within the timeframes required by CMS.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	HealthSpring must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	HealthSpring must revise its policies and procedures to include the following provisions: - to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change, and - to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must include an effective date of change on every EOB in order to meet CMS requirements.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	HealthSpring must revise its policies and procedures to contain the following provisions: - a provision for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, - a provision with a description of the procedures for providing a notice of "maintenance" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of "other" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	HealthSpring must revise its Transition Process policies and procedures to include requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and to include a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must develop a system to track and provide reports regarding HealthSpring's transition process utilization for LTC residents. This documentation must demonstrate to CMS that HealthSpring correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements, as well as the ability to document that HealthSpring has and implements a transition process that covers an emergency supply or "first fill" of non-formulary Part D drugs.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	HealthSpring must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. HealthSpring must demonstrate that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	HealthSpring must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to include a provision for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. HealthSpring also must revise its policies and procedures to include a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee's appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that the Sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	HealthSpring must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) HealthSpring must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, (2) HealthSpring must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (3) and HealthSpring must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. HealthSpring must ensure that all enrollees are provided with written notification of its decision regarding standard coverage determinations concerning payment within the CMS approved timeframe. If HealthSpring fails to make the coverage determination within the CMS-approved timeframe, it must ensure that it forwards the request to the IRE within the CMS-approved timeframe and timely notifies the enrollee that his or her request has been forwarded. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	HealthSpring must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party). HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of the audit. HealthSpring must ensure that enrollees are provided with a denial notice, when appropriate, and that this is documented. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HealthSpring must revise its policies and procedures to develop a process for issuing prompt decisions on expedited determinations in accordance with CMS requirements. The policy should state that HealthSpring must grant a request for an expedited determination if it determines, based on the enrollee's request, or as indicated in the prescribing physician's request that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. HealthSpring must revise its policies and procedures to include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations. HealthSpring must revise its policies and procedures to include a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.		Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	HealthSpring must revise its policies and procedures to include the following provisions: oral and written notice must provide an explanation that HealthSpring must process the request using the 72 hour timeframe for standard determinations, oral and written notice must inform the enrollee of the right to file an expedited grievance, oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and oral and written notice must provide instructions about HealthSpring's grievance process and its timeframes. HealthSpring must provide CMS with a CMS-approved notice, Notice of Right to an Expedited Grievance. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that if a decision is adverse and HealthSpring first notifies the enrollee of the determination orally, HealthSpring must mail written confirmation to the enrollee within 3 calendar days of the oral notification. HealthSpring must revise its policies and procedures to include a provision to inform the enrollee, within 24 hours, when his or her case is forwarded to the IRE. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	HealthSpring must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. HealthSpring must revise its policies and procedures to include a provision stating that if oral notice is provided for the adverse decision, the notice must satisfy the following requirements: (1) states the specific reason for the denial and takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, (2) provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf, and (3) provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must demonstrate to CMS that it uses the correct notice when an enrollee¿s request is denied.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must develop policies and procedures regarding processing requests to its tiered cost-sharing structure that contain the required provisions. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must revise its policies and procedures to include the required provisions regarding processing requests for exceptions for non-formulary drugs. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	HealthSpring must revise its policies and procedures to include provisions stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and all approved non-formulary drugs must be placed in existing cost-sharing tier(s). HealthSpring must provide documentation to CMS that it places all approved non-formulary drugs in existing cost-sharing tiers, in order to demonstrate compliance with this CMS-requirement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	HealthSpring must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must document and notify enrollees of whether their complaint is subject to grievance or coverage determination processes, per CMS requirements. HealthSpring must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	HealthSpring must revise its policies and procedures to ensure they include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. HealthSpring must revise its grievance tracking system to ensure that it captures and maintains the minimum information required: date of receipt of the grievance, mode of receipt of grievance, person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and the date the enrollee was notified of the disposition, and provide CMS with documentation to demonstrate this. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	HealthSpring must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances. HealthSpring must resolve enrollee grievances and do so within the timeframes specified by CMS.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	HealthSpring must ensure it responds to enrollee grievances in accordance with CMS requirements and provide documentation of this to CMS.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	HealthSpring must revise its policies and procedures to include provisions for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must demonstrate that it uses the correct notices when an enrollee's request is denied.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision that indicates that notification of a favorable decision may be made orally or in writing. HealthSpring must document that it notifies enrollees of the expedited redetermination decision and request for medication information within the approved CMS timeframes, and provide this documentation to CMS. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4407	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	HealthSpring must provide documentation to CMS that demonstrates that it uses appropriate personnel to conduct redeterminations. HealthSpring must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, HealthSpring must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician. CMS may request additional sample cases to determine that HealthSpring is in compliance with this requirement.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	HealthSpring must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	HealthSpring must revise its policies and procedures to include the following provisions: - to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change, and - to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must include an effective date of change on every EOB in order to meet CMS requirements.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	HealthSpring must revise its policies and procedures to contain the following provisions: - a provision for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, - a provision with a description of the procedures for providing a notice of maintenance formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of other formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	HealthSpring must revise its Transition Process policies and procedures to include requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and to include a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must develop a system to track and provide reports regarding HealthSpring's transition process utilization for LTC residents. This documentation must demonstrate to CMS that HealthSpring correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements, as well as the ability to document that HealthSpring has and implements a transition process that covers an emergency supply or "first fill" of non-formulary Part D drugs.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	HealthSpring must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. HealthSpring must demonstrate that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	HealthSpring must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to include a provision for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. HealthSpring also must revise its policies and procedures to include a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee's appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that the Sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	HealthSpring must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) HealthSpring must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, (2) HealthSpring must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (3) and HealthSpring must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. HealthSpring must ensure that all enrollees are provided with written notification of its decision regarding standard coverage determinations concerning payment within the CMS approved timeframe. If HealthSpring fails to make the coverage determination within the CMS-approved timeframe, it must ensure that it forwards the request to the IRE within the CMS-approved timeframe and timely notifies the enrollee that his or her request has been forwarded. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	HealthSpring must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party). HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of the audit. HealthSpring must ensure that enrollees are provided with a denial notice, when appropriate, and that this is documented. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HealthSpring must revise its policies and procedures to discuss means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, and state that it must grant a request for an expedited determination if it determines, based on the enrollee's request, or as indicated in the prescribing physician's request that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. HealthSpring must revise its policies and procedures to include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations. HealthSpring must revise its policies and procedures to include a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	HealthSpring must revise its policies and procedures to include the following provisions for handling a denied request for an expedited coverage determination: automatically transferring the request to the standard coverage determination process and giving the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently delivering (i.e., mailing) to the enrollee, within 3 calendar days, written notice. HealthSpring must document the request for additional information from the enrollee's physician when denying a coverage determination based on the lack of supporting medical information. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	HealthSpring must revise its policies and procedures to include the following provisions: oral and written notice must provide an explanation that HealthSpring must process the request using the 72 hour timeframe for standard determinations, oral and written notice must inform the enrollee of the right to file an expedited grievance, oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and oral and written notice must provide instructions about HealthSpring's grievance process and its timeframes. HealthSpring must provide CMS with a CMS-approved notice, Notice of Right to an Expedited Grievance. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that if a decision is adverse and HealthSpring first notifies the enrollee of the determination orally, HealthSpring must mail written confirmation to the enrollee within 3 calendar days of the oral notification. HealthSpring must revise its policies and procedures include a provision to inform the enrollee, within 24 hours, when his or her case is forwarded to the IRE. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	HealthSpring must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. HealthSpring must revise its policies and procedures to include a provision stating that if oral notice is provided for the adverse decision, the notice must satisfy the following requirements: states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any -- provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf -- and provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must demonstrate to CMS that it uses the correct notice when an enrollee¿s request is denied.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must develop policies and procedures regarding processing requests to its tiered cost-sharing structure that contain the required provisions. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must revise its policies and procedures to include the required provisions regarding processing requests for exceptions for non-formulary drugs. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	HealthSpring must revise its policies and procedures to include provisions stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and all approved non-formulary drugs must be placed in existing cost-sharing tier(s). HealthSpring must provide documentation to CMS that it places all approved non-formulary drugs in existing cost-sharing tiers, in order to demonstrate compliance with this CMS-requirement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	HealthSpring must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must document and notify enrollees of whether their complaint is subject to grievance or coverage determination processes, per CMS requirements. HealthSpring must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	HealthSpring must revise its policies and procedures to ensure they include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. HealthSpring must revise its grievance tracking system to ensure that it captures and maintains the minimum information required: date of receipt of the grievance, mode of receipt of grievance, person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and the date the enrollee was notified of the disposition, and provide CMS with documentation to demonstrate this. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	HealthSpring must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances. HealthSpring must resolve enrollee grievances and do so within the timeframes specified by CMS.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	HealthSpring must ensure it responds to enrollee grievances in accordance with CMS requirements and provide documentation of this to CMS.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	HealthSpring must revise its policies and procedures to include provisions for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must demonstrate that it uses the correct notices when an enrollees request is denied.	Closed
HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision that indicates that notification of a favorable decision may be made orally or in writing. HealthSpring must document that it notifies enrollees of the expedited redetermination decision and request for medication information within the approved CMS timeframes, and provide this documentation to CMS. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4454	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	HealthSpring must provide documentation to CMS that demonstrates that it uses appropriate personnel to conduct redeterminations. HealthSpring must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, HealthSpring must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician. CMS may request additional sample cases to determine that HealthSpring is in compliance with this requirement.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	HealthSpring must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	HealthSpring must revise its policies and procedures to include the following provisions: - to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change, and - to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must include an effective date of change on every EOB in order to meet CMS requirements.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	HealthSpring must revise its policies and procedures to contain the following provisions: - a provision for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, - a provision with a description of the procedures for providing a notice of "maintenance" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of "other" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	HealthSpring must revise its Transition Process policies and procedures to include requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and to include a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must develop a system to track and provide reports regarding HealthSpring's transition process utilization for LTC residents. This documentation must demonstrate to CMS that HealthSpring correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements, as well as the ability to document that HealthSpring has and implements a transition process that covers an emergency supply or "first fill" of non-formulary Part D drugs.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	HealthSpring must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. HealthSpring must demonstrate that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	HealthSpring must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to include a provision for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. HealthSpring also must revise its policies and procedures to include a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee's appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that the Sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	HealthSpring must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) HealthSpring must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, (2) HealthSpring must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (3) and HealthSpring must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. HealthSpring must ensure that all enrollees are provided with written notification of its decision regarding standard coverage determinations concerning payment within the CMS approved timeframe. If HealthSpring fails to make the coverage determination within the CMS-approved timeframe, it must ensure that it forwards the request to the IRE within the CMS-approved timeframe and timely notifies the enrollee that his or her request has been forwarded. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	HealthSpring must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party). HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of the audit. HealthSpring must ensure that enrollees are provided with a denial notice, when appropriate, and that this is documented. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HealthSpring must revise its policies and procedures to discuss means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, and state that it must grant a request for an expedited determination if it determines, based on the enrollee's request, or as indicated in the prescribing physician's request that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. HealthSpring must revise its policies and procedures to include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations. HealthSpring must revise its policies and procedures to include a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	HealthSpring must revise its policies and procedures to include the following provisions for handling a denied request for an expedited coverage determination: automatically transferring the request to the standard coverage determination process and giving the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently delivering (i.e., mailing) to the enrollee, within 3 calendar days, written notice. HealthSpring must document the request for additional information from the enrollee's physician when denying a coverage determination based on the lack of supporting medical information. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	HealthSpring must revise its policies and procedures to include the following provisions: oral and written notice must provide an explanation that HealthSpring must process the request using the 72 hour timeframe for standard determinations, oral and written notice must inform the enrollee of the right to file an expedited grievance, oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and oral and written notice must provide instructions about HealthSpring's grievance process and its timeframes. HealthSpring must provide CMS with a CMS-approved notice, Notice of Right to an Expedited Grievance. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that if a decision is adverse and HealthSpring first notifies the enrollee of the determination orally, HealthSpring must mail written confirmation to the enrollee within 3 calendar days of the oral notification. HealthSpring must revise its policies and procedures include a provision to inform the enrollee, within 24 hours, when his or her case is forwarded to the IRE. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	HealthSpring must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. HealthSpring must revise its policies and procedures to include a provision stating that if oral notice is provided for the adverse decision, the notice must satisfy the following requirements: (1) states the specific reason for the denial and takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, (2) provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf and (3) provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must demonstrate to CMS that it uses the correct notice when an enrollee's request is denied.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must develop policies and procedures regarding processing requests to its tiered cost-sharing structure that contain the required provisions. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must revise its policies and procedures to include the required provisions regarding processing requests for exceptions for non-formulary drugs. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	HealthSpring must revise its policies and procedures to include provisions stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and all approved non-formulary drugs must be placed in existing cost-sharing tier(s). HealthSpring must provide documentation to CMS that it places all approved non-formulary drugs in existing cost-sharing tiers, in order to demonstrate compliance with this CMS-requirement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	HealthSpring must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must document and notify enrollees of whether their complaint is subject to grievance or coverage determination processes, per CMS requirements. HealthSpring must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	HealthSpring must revise its policies and procedures to ensure they include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. HealthSpring must revise its grievance tracking system to ensure that it captures and maintains the minimum information required: date of receipt of the grievance, mode of receipt of grievance, person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and the date the enrollee was notified of the disposition, and provide CMS with documentation to demonstrate this. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	HealthSpring must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances. HealthSpring must resolve enrollee grievances and do so within the timeframes specified by CMS.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	HealthSpring must ensure it responds to enrollee grievances in accordance with CMS requirements and provide documentation of this to CMS.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	HealthSpring must revise its policies and procedures to include provisions for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must demonstrate that it uses the correct notices when an enrollee's request is denied.	Closed

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HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision that indicates that notification of a favorable decision may be made orally or in writing. HealthSpring must document that it notifies enrollees of the expedited redetermination decision and request for medication information within the approved CMS timeframes, and provide this documentation to CMS. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	HealthSpring must provide documentation to CMS that demonstrates that it uses appropriate personnel to conduct redeterminations. HealthSpring must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, HealthSpring must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician. CMS may request additional sample cases to determine that HealthSpring is in compliance with this requirement.	Closed
HealthSpring, Inc.	1-615-236-6116	H0150	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HealthSpring must demonstrate to CMS that it effectuates a decision that has been reversed by the IRE for cases concerning a drug benefit within the timeframes required by CMS.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	HealthSpring must revise its policies and procedures to include a provision to provide retrospective notice of formulary change to authorized prescribers, network pharmacies, and pharmacists if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	HealthSpring must revise its policies and procedures to include the following provisions: - to provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or if no prior notice is given, to ensure that affected enrollees are provided with a 60 day supply of the Part D drug under the same terms as previously allowed at the time a refill is requested, and are provided written notice of the formulary change, and - to provide retrospective notice to affected enrollees if a covered Part D drug is immediately removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must include an effective date of change on every EOB in order to meet CMS requirements.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	HealthSpring must revise its policies and procedures to contain the following provisions: - a provision for providing retrospective notice to CMS, SPAPs, and entities providing other prescription drug coverage if a covered Part D drug is removed from the formulary because it is deemed unsafe by the FDA or removed from the market by the manufacturer, - a provision with a description of the procedures for providing a notice of "maintenance"formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements, and - a provision with a description of the procedures for providing a notice of "other" formulary changes to CMS, SPAPs, and entities providing other prescription drug coverage, in accordance with CMS requirements. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	HealthSpring must revise its Transition Process policies and procedures to include requirements for addressing the immediate needs of LTC beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and to include a provision to abide by extensions to the transition period in accordance with CMS policy. HealthSpring must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must develop a system to track and provide reports regarding HealthSpring's transition process utilization for LTC residents. This documentation must demonstrate to CMS that HealthSpring correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements, as well as the ability to document that HealthSpring has and implements a transition process that covers an emergency supply or "first fill" of non-formulary Part D drugs.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	HealthSpring must revise its policies and procedures to include a provision for sending the "Medicare Prescription Drug Coverage and Your Rights" notice to the location in the LTC facility designated to accept such notices, or if the network or preferred pharmacy is on-site, delivering the notice described above to the location in the LTC facility designated to accept such notices. HealthSpring must demonstrate that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	HealthSpring must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations to include a provision for making timely coverage determinations (standard and expedited) that address basic coverage, supplemental benefits, and cost sharing. HealthSpring also must revise its policies and procedures to include a provision stating that individuals who can request a standard or expedited coverage determination are (1) the enrollee, (2) the enrollee's appointed representative, on behalf of the enrollee, and (3) the prescribing physician, on behalf of the enrollee. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that the Sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	HealthSpring must revise its policies and procedures to include provisions that address the following requirements regarding coverage determinations concerning payment: (1) HealthSpring must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement, (2) HealthSpring must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, (3) and HealthSpring must make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. HealthSpring must ensure that all enrollees are provided with written notification of its decision regarding standard coverage determinations concerning payment within the CMS approved timeframe. If HealthSpring fails to make the coverage determination within the CMS-approved timeframe, it must ensure that it forwards the request to the IRE within the CMS-approved timeframe and timely notifies the enrollee that his or her request has been forwarded. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	HealthSpring must revise its policies and procedures to include a provision stating that adverse coverage determinations, in whole or in part, require written notification to the enrollee (and/or other applicable party). HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of the audit. HealthSpring must ensure that enrollees are provided with a denial notice, when appropriate, and that this is documented. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	HealthSpring must revise its policies and procedures to discuss means for issuing prompt decisions on expediting determinations in accordance with CMS requirements, and state that it must grant a request for an expedited determination if it determines, based on the enrollee's request, or as indicated in the prescribing physician's request that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. HealthSpring must revise its policies and procedures to include the name of a designated office and/or department to receive both oral and written requests, including a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited coverage determinations. HealthSpring must revise its policies and procedures to include a provision for making expedited decisions within the appropriate timeframe for requests received outside of normal business hours. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.	HealthSpring must revise its policies and procedures to include the following provisions for handling a denied request for an expedited coverage determination: automatically transferring the request to the standard coverage determination process and giving the enrollee and his or her prescribing physician, if involved, prompt oral notice of the denial, and subsequently delivering (i.e., mailing) to the enrollee, within 3 calendar days, written notice. HealthSpring must document the request for additional information from the enrollee's physician when denying a coverage determination based on the lack of supporting medical information. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	HealthSpring must revise its policies and procedures to include the following provisions: oral and written notice must provide an explanation that HealthSpring must process the request using the 72 hour timeframe for standard determinations, oral and written notice must inform the enrollee of the right to file an expedited grievance, oral and written notice must inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician's support, and oral and written notice must provide instructions about HealthSpring's grievance process and its timeframes. HealthSpring must provide CMS with a CMS-approved notice, Notice of Right to an Expedited Grievance. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision stating that if a decision is adverse and HealthSpring first notifies the enrollee of the determination orally, HealthSpring must mail written confirmation to the enrollee within 3 calendar days of the oral notification. HealthSpring must revise its policies and procedures include a provision to inform the enrollee, within 24 hours, when his or her case is forwarded to the IRE. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	HealthSpring must revise its policies and procedures to include a provision stating that if the decision is adverse, then it must use a notice consistent with the CMS-issued standard notice, Notice of Denial of Medicare Prescription Drug Coverage. HealthSpring must revise its policies and procedures to include a provision stating that if oral notice is provided for the adverse decision, the notice must satisfy the following requirements: states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any -- provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf -- and provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. HealthSpring must provide CMS with a CMS-approved notice, Notice of Denial of Medicare Prescription Drug Coverage. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. HealthSpring must demonstrate to CMS that it uses the correct notice when an enrollee's request is denied.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must develop policies and procedures regarding processing requests to its tiered cost-sharing structure that contain the required provisions. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	HealthSpring must revise its policies and procedures to include the required provisions regarding processing requests for exceptions for non-formulary drugs. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	HealthSpring must revise its policies and procedures to include provisions stating that coverage is provided for approved tiering exceptions at the same cost-sharing level as preferred drugs, enrollees are not required to request an approval following the initial prescription for the remainder of the plan year, and all approved non-formulary drugs must be placed in existing cost-sharing tier(s). HealthSpring must provide documentation to CMS that it places all approved non-formulary drugs in existing cost-sharing tiers, in order to demonstrate compliance with this CMS-requirement. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	HealthSpring must provide CMS with a CMS-approved notice, Notice of Inquiry Regarding an Excluded Drug. If HealthSpring does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. HealthSpring must document and notify enrollees of whether their complaint is subject to grievance or coverage determination processes, per CMS requirements. HealthSpring must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	HealthSpring must revise its policies and procedures to ensure they include a provision for tracking and maintaining, at a minimum, the date the grievance was received, disposition of the grievance, and the date that the enrollee was notified of the disposition. HealthSpring must revise its grievance tracking system to ensure that it captures and maintains the minimum information required: date of receipt of the grievance, mode of receipt of grievance, person or entity that filed the grievance, subject of the grievance, disposition of the grievance, and the date the enrollee was notified of the disposition, and provide CMS with documentation to demonstrate this. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	HealthSpring must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decision within the CMS-approved timeframe, and that it documents the resolutions to enrollees' grievances. HealthSpring must resolve enrollee grievances and do so within the timeframes specified by CMS.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	HealthSpring must ensure it responds to enrollee grievances in accordance with CMS requirements and provide documentation of this to CMS.	Closed

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HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	HealthSpring must revise its policies and procedures to include provisions for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, and the name of a designated office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited appeals. HealthSpring must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must demonstrate that it uses the correct notices when an enrollee's request is denied.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	HealthSpring must revise its policies and procedures to include a provision that indicates that notification of a favorable decision may be made orally or in writing. HealthSpring must document that it notifies enrollees of the expedited redetermination decision and request for medication information within the approved CMS timeframes, and provide this documentation to CMS. HealthSpring must conduct training of appropriate staff on each of these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	HealthSpring must provide documentation to CMS that demonstrates that it uses appropriate personnel to conduct redeterminations. HealthSpring must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, HealthSpring must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician. CMS may request additional sample cases to determine that HealthSpring is in compliance with this requirement.	Closed
HealthSpring, Inc.	1-615-236-6116	H4513	MA-PD	Audit Findings	4/27/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	HealthSpring must demonstrate to CMS that it effectuates a decision that has been reversed by the IRE for cases concerning drug benefit within the timeframes required by CMS.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA	Audit Findings	4/19/2007	Closed	Chapter 02 - Enrollment and Disenrollment (Enrollment)	Enrollment Acknowledgement (Timeliness) - The M+CO notifies the beneficiary of receipt of the enrollment form within timeframes specified by CMS.	MAO must provide CMS with a written plan to monitor TMG's performance in this area. In addition, the MAO must conduct monthly audits of TMG's performance and report the findings to CMS for a period of six consecutive months.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA	Audit Findings	4/19/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The M+CO establishes and maintains a marketing system for confirming that enrolled members understand that they are enrolled in the M+C plan, and understand the rules applicable under the plan.	The MAO must provide CMS with their verification call audit results beginning November 15, 2006 to date. The MAO must provide this monthly until further notice.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA	Audit Findings	4/19/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	The MAO must provide written monthly updates to CMS regarding provider and consumer outreach activities, continuing communication with advocacy groups and state agencies, status of broker/agent retraining, and a summary of ongoing sales management oversight of broker activities. The MAO must provide monthly written reports of complaints and their disposition. Each report must be accompanied by a summary which includes source of complaints, an analysis of trends, a determination of the likely cause of complaints, and a plan of action to prevent similar complaints. The MAO must provide CMS with the most recent satisfaction survey and each subsequent survey. The MAO must provide CMS with rapid disenrollment rates by market. Rapid disenrollments are defined as those disenrollments that occur within 3 months of enrollment.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Organization Determinations and Reconsiderations Not Categorized as Grievances - The M+CO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	WellCare must produce a universe that is correct and representative of this element. Additionally, WellCare must correct its internal policies and procedures to be consistent with its EOC. The Organ ization must also develop sufficient operating procedures to ensure that complaints are processed in accordance with its internal policy and procedures.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Grievance Adjudication - The M+CO must adjudicate internal grievances in a manner fully consistent with the M+CO's written grievance procedure, as stated in the EOC.	WellCare must produce a universe that is correct and representative of this element. Additionally, WellCare must correct its internal policies and procedures to be consistent with its EOC. The Organ ization must also develop sufficient operating procedures to ensure that complaints are processed in accordance with its internal policy and procedures.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H1340	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	WellCare must develop a policy and procedure to ensure their delegated providers include the standard denial notice and the appeal rights with all denied claims. This policy and procedure must include a training program along with a training manual. WellCare must develop a policy and procedure for monitoring the delegated providers. This policy and procedure must include, but not be limited to, who will be conducting the monitoring, the frequency of the monitoring and what action will be taken if the delegated provider is having difficulty adhearing to the procedures outlined in the training program and manual.	Closed

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WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA	Audit Findings	4/19/2007	Closed	Chapter 02 - Enrollment and Disenrollment (Enrollment)	Enrollment Acknowledgement (Timeliness) - The M+CO notifies the beneficiary of receipt of the enrollment form within timeframes specified by CMS.	MAO must provide CMS with a written plan to monitor TMG's performance in this area. In addition, the MAO must conduct monthly audits of TMG's performance and report the findings to CMS for a period of six consecutive months.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA	Audit Findings	4/19/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The M+CO establishes and maintains a marketing system for confirming that enrolled members understand that they are enrolled in the M+C plan, and understand the rules applicable under the plan.	The MAO must provide CMS with their verification call audit results beginning November 15, 2006 to date. The MAO must provide this monthly until further notice.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA	Audit Findings	4/19/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	The MAO must provide written monthly updates to CMS regarding provider and consumer outreach activities, continuing communication with advocacy groups and state agencies, status of broker/agent retraining, and a summary of ongoing sales management oversight of broker activities. The MAO must provide monthly written reports of complaints and their disposition. Each report must be accompanied by a summary which includes source of complaints, an analysis of trends, a determination of the likely cause of complaints, and a plan of action to prevent similar complaints. The MAO must provide CMS with the most recent satisfaction survey and each subsequent survey. The MAO must provide CMS with rapid disenrollment rates by market. Rapid disenrollments are defined as those disenrollments that occur within 3 months of enrollment.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Organization Determinations and Reconsiderations Not Categorized as Grievances - The M+CO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	WellCare must produce a universe that is correct and representative of this element. Additionally, WellCare must correct its internal policies and procedures to be consistent with its EOC. The Organ ization must also develop sufficient operating procedures to ensure that complaints are processed in accordance with its internal policy and procedures.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Grievance Adjudication - The M+CO must adjudicate internal grievances in a manner fully consistent with the M+CO's written grievance procedure, as stated in the EOC.	WellCare must produce a universe that is correct and representative of this element. Additionally, WellCare must correct its internal policies and procedures to be consistent with its EOC. The Organ ization must also develop sufficient operating procedures to ensure that complaints are processed in accordance with its internal policy and procedures.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H4577	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	WellCare must develop a policy and procedure to ensure their delegated providers include the standard denial notice and the appeal rights with all denied claims. This policy and procedure must include a training program along with a training manual. WellCare must develop a policy and procedure for monitoring the delegated providers. This policy and procedure must include, but not be limited to, who will be conducting the monitoring, the frequency of the monitoring and what action will be taken if the delegated provider is having difficulty adhearing to the procedures outlined in the training program and manual.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA	Audit Findings	4/19/2007	Closed	Chapter 02 - Enrollment and Disenrollment (Enrollment)	Enrollment Acknowledgement (Timeliness) - The M+CO notifies the beneficiary of receipt of the enrollment form within timeframes specified by CMS.	MAO must provide CMS with a written plan to monitor TMG's performance in this area. In addition, the MAO must conduct monthly audits of TMG's performance and report the findings to CMS for a period of six consecutive months.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA	Audit Findings	4/19/2007	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The M+CO establishes and maintains a marketing system for confirming that enrolled members understand that they are enrolled in the M+C plan, and understand the rules applicable under the plan.	The MAO must provide CMS with their verification call audit results beginning November 15, 2006 to date. The MAO must provide this monthly until further notice.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA	Audit Findings	4/19/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	The MAO must provide written monthly updates to CMS regarding provider and consumer outreach activities, continuing communication with advocacy groups and state agencies, status of broker/agent retraining, and a summary of ongoing sales management oversight of broker activities. The MAO must provide monthly written reports of complaints and their disposition. Each report must be accompanied by a summary which includes source of complaints, an analysis of trends, a determination of the likely cause of complaints, and a plan of action to prevent similar complaints. The MAO must provide CMS with the most recent satisfaction survey and each subsequent survey. The MAO must provide CMS with rapid disenrollment rates by market. Rapid disenrollments are defined as those disenrollments that occur within 3 months of enrollment.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Organization Determinations and Reconsiderations Not Categorized as Grievances - The M+CO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	WellCare must produce a universe that is correct and representative of this element. Additionally, WellCare must correct its internal policies and procedures to be consistent with its EOC. The Organ ization must also develop sufficient operating procedures to ensure that complaints are processed in accordance with its internal policy and procedures.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Grievance Adjudication - The M+CO must adjudicate internal grievances in a manner fully consistent with the M+CO's written grievance procedure, as stated in the EOC.	WellCare must produce a universe that is correct and representative of this element. Additionally, WellCare must correct its internal policies and procedures to be consistent with its EOC. The Organ ization must also develop sufficient operating procedures to ensure that complaints are processed in accordance with its internal policy and procedures.	Closed
WellCare Health Plans, Inc.	1-813-290-6200 Ext. 2762	H6499	MA	Audit Findings	4/19/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	WellCare must develop a policy and procedure to ensure their delegated providers include the standard denial notice and the appeal rights with all denied claims. This policy and procedure must include a training program along with a training manual. WellCare must develop a policy and procedure for monitoring the delegated providers. This policy and procedure must include, but not be limited to, who will be conducting the monitoring, the frequency of the monitoring and what action will be taken if the delegated provider is having difficulty adhearing to the procedures outlined in the training program and manual.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.	Universal Health Plan must follow their own disenrollment policy and procedure (DER-4) which states that a copy of the request for disenrollment and a disenrollment letter will be provided to the beneficiary within seven days of receipt of the request to disenroll. Universal Health Plan must provide training to the appropriate staff on this procedure and submit training material and attendance log to the Atlanta regional office. The training must be completed and the information sent to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Refund of Premium - The MAO must refund all amounts incorrectly collected from its Medicare members or from others on their behalf.	Universal Health Plan must adhere to their policy and procedure DER 11 and ensure that members are refunded any premiums collected incorrectly. Universal Health Plan must review each sample case and provide evidence to CMS that a refund was sent to the member. This information must be sent to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Involuntary Disenrollment for Move Out of Service Area - The MAO must disenroll Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than six (6) months, unless they move into an approved plan continuation area and the member has elected the continuation of enrollment option. Member notice is required prior to transmission of the disenrollment to CMS.	Universal Health Plan (UHC) must conduct training to appropriate staff on their own internal policies and procedures (DER 8 and DER 14) which stipulates how to correctly identify voluntary and involuntary disenrollments. UHC must submit documentation to the regional office that details the nature of the training, including the materials used, the individuals conducting the training, and the individuals being trained. This information is due to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Receipt - Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.	UHC must revise its current policies and procedures to ensure that the Enrollment Election Receipt-Dated Elections are appropriately dated as of the date they are received by the MAO. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS.	UHC must modify it's current practices to make certain that it notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Acknowledgement (Notice Content) - The written acknowledgement notice, sent in response to the beneficiary's enrollment election, meets CMS requirements and specifies the correct effective date of enrollment.	UHC must revise its "Notice to Acknowledge Receipt of Completed Enrollment Election" and revise its current policies and procedures to ensure that the Enrollment Acknowledgement (Notice Content) element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	UHC must revise its current policies and procedures to ensure that this element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe includes a list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe is the complete list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Submission of Enrollment Transactions to CMS - The MAO follows CMS guidelines for submitting enrollment transactions to CMS.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe is the complete list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Retroactive Enrollment Requests - The MAO requests retroactive enrollments when required, due to CMS enrollment rejection error, and adheres to CMS requirements in requesting retroactive enrollments from the Regional Office or Program Safeguard Contractor.	UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe is the complete list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Appropriate Follow-Up on Changes in State and County Code - The MAO reviews the CMS Monthly Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follows-up on any change in residence for its members reported to it by CMS.	UHC must revise its current policies and procedures to ensure compliance with this element. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	The MAO must provide to CMS a written plan on how it will provide oversight of the 13 FMOs and its brokers. The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The MAO must provide training to all of its marketing representatives and this training must be documented in their personnel files. The MAO must investigate all marketing complaints on their inquiry log and provide CMS with their resolution. The MAO's management must provide assurances to CMS that they will provide oversight of their marketing staff to ensure future compliance in this area. The MAO must provide to CMS, for the next 12 months, a report of all marketing allegations they receive directly and through CTM with the results of their investigations and the resolutions. All requested documentation and the first report are due to the Regional Office by the end of April 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.	UHC must implement the following: 1. Construct a process which will provide for the development of accurate HSD tables. CMS recommends including subject matter experts from various departments within the agency in this process. Suggeted participants/departments include but are not limited to: a. Clinical staff from UM and Quality Management b. MIS c. Provider Relations 2. Provide to CMS the policies, procedures, and guidelines for the following: a. Accessibility and Availability guidelines for urban and rural network development. b. Strategies for network development and payment when specialists are available but refuse to contract with the Medicare Advantage Organization. c. Guidelines for analyzing the population for geographical penetration of Medicare eligibles, provider panels, and high referral specialists related to provider and population needs. These should also be based on local practice patterns of the population. 3. Create policies and procedures for the development of narratives to explain issues that cannot be addressed on the HSD tables. These include but are not limited to: a. Out of area services based upon practice patterns of the population. b. How services will be made available when providers cannot be contracted within an approved service area. c. Services provided in rural areas outside of CMS access standards, but which are consistent with practice patterns of care. d. Service gaps within a county. 4. Create internal systems which allow for the review of information for accuracy and relevancy before it is sent to CMS. These systems should target but not be limited to, consistency between HSD tables, contract types, and contract signature pages. 5. Submit a sample of HSD tables 1, 2, and 4 which have been created utilizing this new process for building HSD tables to the regional office. These should be submitted to CMS by the end of April 2007. 6. Submit revised HSD 3 tables to the regional office by the end of April 2007. Address whether UHC will seek to obtain contracts for the gaps in the network and specify how enrollees will have access to those services. 7. Submit a quarterly Medicare Provider Network Analysis Reports to the regional office for all counties in the approved service area. The first report will be due to CMS at the end of June 2007. 8. A contingency action plan which addresses: a. Strategies of how the remaining contracted providers will provide inpatient and outpatient services in the network. b. Additional Contracting c. Payment for claims to contracting and non-contracting providers d. Member notification letter addressing how services are to be obtained e. Expected timeframes of completion of each task f. How the MAO will transition:	Closed

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									(1) Members who have prior authorizations and scheduled outpatient procedures with providers who have terminated their contract with UHC. (2) Procedures for members who are currently hospitalized, currently under case management, or receiving specialized service such as dialysis recipients, chemotherapy recipients, and other identified chronically ill members whose providers have terminated their contract with UHC. The action plan should include short and long term goals of how these services will be obtained immediately as well as how UHC is working toward permanently correcting the network issues. Documentation supporting the implementation of the above processes must be submitted to the regional office by the end of April 2007.	
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 05 - Quality Assurance	Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.	UHC must develop and implement the following: 1. Implement the UM plan and program as outlined in the MAO's policies and procedures. 2. Develop a process for sharing relevant information with all departments, providers, and committees such as QA, UM, claims, appeals, grievances, and peer review. 3. Develop a committee structure which expands and incorporates members of the relevant departments into the QA, UM, and Peer Review committees. 4. Develop a process to evaluate the current UM reports and add new relevant reports to the Information System. 5. Audit the denial on retrospective review process of claims to identfy the denial of emergent/urgent care. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	UHC must develop and implement the following: 1. Updated policies and procedures to incorporate the functions of a formal peer review committee. 2. Submit to CMS minutes of the peer review committee to verify that the following are implemented: a. Tracking and trending of quality of care issues. b. Reporting of variances and violations to the appropriate agencies for investigation (i.e. wound infection frequency in surgical patients. c. Any remedial action taken for severe cases or cases which have a large scope. These issues should be forwarded to the Board of Directors for appropriate action. d. Organize and annotate minutes for both the MAC and peer review committees to provide detailed minutes for distribution to the Quality Management Steering Committee. e. Coordinate a formal provider remedial system for actions pertaining to quality of care cases. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	UHC must develop and implement the following: 1. A corrective action plan which will outline the process that UHC will develop to ensure compliance with this element. 2. Adherence to the credentialing process as outlined in UHC's policy and procedures which require all ancillary providers to fill out an application for processing. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.	UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.	Closed

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Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.	UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's grievance process. 2. A training program for the appeal and grievance staff. Please provide to CMS the training manual, the individuals conducting the training and a list of the individuals trained. 3. An internal audit system designed to evaluate whether or not grievances are resolved within the timeframes specified in the organization's policies and procedures. 4. A process which requires the appeals/grievance committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must pay the interest on the 2 identified claims were interest was not paid. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by April 30, 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and statement of denial reasons for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for favorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. 4. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the favorable standard pre-service reconsideration process. 2. An internal audit system designed to evaluate whether or not overturns are authorized within the timeframes in the organization's policies and procedures. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the unfavorable standard pre-service reconsideration process. 2. An internal audit system designed to evaluate whether or not denied cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Health Care Inc.	1-727-456-6534 Ext. 6534	H5404	MA	Audit Findings	3/31/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the requests for expedited reconsideration process. 2. An internal audit system designed to evaluate whether or not cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Wellpoint, Inc.	1-303-831-2514	H0540	MA	Audit Findings	3/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	Wellpoint must provide CMS with a plan of correction that will quickly reduce the backlog of claims. This remediation must ensure that claims determinations are made correctly, claims paid accurately, and interest is included when appropriate. Furthermore, Wellpoint must develop a process for differentiating clean and non-clean claims as well as paying each type of claim timely. Wellpoint must submit bi-weekly reports to CMS that detail current number of outstanding claims broken down by age, number of clean and non-clean claims as well as the number of claims on which interest was paid. Wellpoint must also submit a plan of correction that will adequately address the call center hold times and abandonment rates. CMS understands that the volume will decrease as the claims backlog is resolved. However Wellpoint must have a process to handle increasing call volumes regardless of the reason. Lastly, Wellpoint must submit bi-weekly reports to CMS that detail call volume for both members and providers, number of calls answered, percentage of calls answered, total number of abandoned calls, number of calls answered in 30 seconds, AHT, and ASA. Wellpoint must update CMS on any changes (positive or negative) to their plan of correction.	Closed
Wellpoint, Inc.	1-303-831-2514	H0540	MA	Audit Findings	3/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Timely Payment of Non-Contracting Provider Clean Claims - The M+CO must pay 95 percent of "clean" claims from all providers within 30 calendar days of receipt.	Wellpoint must provide CMS with a plan of correction that will quickly reduce the backlog of claims. This remediation must ensure that claims determinations are made correctly, claims paid accurately, and interest is included when appropriate. Furthermore, Wellpoint must develop a process for differentiating clean and non-clean claims as well as paying each type of claim timely. Wellpoint must submit bi-weekly reports to CMS that detail current number of outstanding claims broken down by age, number of clean and non-clean claims as well as the number of claims on which interest was paid. Wellpoint must also submit a plan of correction that will adequately address the call center hold times and abandonment rates. CMS understands that the volume will decrease as the claims backlog is resolved. However Wellpoint must have a process to handle increasing call volumes regardless of the reason. Lastly, Wellpoint must submit bi-weekly reports to CMS that detail call volume for both members and providers, number of calls answered, percentage of calls answered, total number of abandoned calls, number of calls answered in 30 seconds, AHT, and ASA. Wellpoint must update CMS on any changes (positive or negative) to their plan of correction.	Closed
Wellpoint, Inc.	1-303-831-2514	H0540	MA	Audit Findings	3/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Timely Adjudication of Non-Clean Claims - The M+CO must pay or deny all claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	Wellpoint must provide CMS with a plan of correction that will quickly reduce the backlog of claims. This remediation must ensure that claims determinations are made correctly, claims paid accurately, and interest is included when appropriate. Furthermore, Wellpoint must develop a process for differentiating clean and non-clean claims as well as paying each type of claim timely. Wellpoint must submit bi-weekly reports to CMS that detail current number of outstanding claims broken down by age, number of clean and non-clean claims as well as the number of claims on which interest was paid. Wellpoint must also submit a plan of correction that will adequately address the call center hold times and abandonment rates. CMS understands that the volume will decrease as the claims backlog is resolved. However Wellpoint must have a process to handle increasing call volumes regardless of the reason. Lastly, Wellpoint must submit bi-weekly reports to CMS that detail call volume for both members and providers, number of calls answered, percentage of calls answered, total number of abandoned calls, number of calls answered in 30 seconds, AHT, and ASA. Wellpoint must update CMS on any changes (positive or negative) to their plan of correction.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Wellpoint, Inc.	1-303-831-2514	H0540	MA	Audit Findings	3/21/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Payment rates under PFFS plan - M+CO must demonstrate to CMS that it has payment rates that are not less than the rates that apply under original Medicare for the provider in question.	Wellpoint must provide CMS with a plan of correction that will quickly reduce the backlog of claims. This remediation must ensure that claims determinations are made correctly, claims paid accurately, and interest is included when appropriate. Furthermore, Wellpoint must develop a process for differentiating clean and non-clean claims as well as paying each type of claim timely. Wellpoint must submit bi-weekly reports to CMS that detail current number of outstanding claims broken down by age, number of clean and non-clean claims as well as the number of claims on which interest was paid. Wellpoint must also submit a plan of correction that will adequately address the call center hold times and abandonment rates. CMS understands that the volume will decrease as the claims backlog is resolved. However Wellpoint must have a process to handle increasing call volumes regardless of the reason. Lastly, Wellpoint must submit bi-weekly reports to CMS that detail call volume for both members and providers, number of calls answered, percentage of calls answered, total number of abandoned calls, number of calls answered in 30 seconds, AHT, and ASA. Wellpoint must update CMS on any changes (positive or negative) to their plan of correction.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 03: Marketing and Beneficiary Information	No Engagement in Activities that Mislead, Confuse or Misrepresent - The Part D sponsor must not engage in prohibited marketing activities that are materially inaccurate, materially mislead, confuse Medicare beneficiaries, or misrepresent the Part D sponsor or its Part D Plan.	America's Health Choice must revise its policies and other documentation to specifically address the Part D marketing activities that are prohibited per 42 CFR § 423.50(f)(1) and the Medicare Marketing Guidelines so that marketing representatives are informed of prohibited activities. AHC must also develop procedures for performing ongoing monitoring of its sales representatives. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 10: Compliance Plan	Comprehensive Fraud and Abuse Plan - The Part D sponsor must have and implement a compliance plan that includes a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse.	The comprehensive plan to detect, correct and prevent fraud, waste and abuse that AHC implemented in January 2007 is sufficient to meet this requirement. Therefore, no further corrective action is required.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 03: Marketing and Beneficiary Information	No Engagement in Activities that Mislead, Confuse or Misrepresent - The Part D sponsor must not engage in prohibited marketing activities that are materially inaccurate, materially mislead, confuse Medicare beneficiaries, or misrepresent the Part D sponsor or its Part D Plan.	America's Health Choice must revise its policies and other documentation to specifically address the Part D marketing activities that are prohibited per 42 CFR § 423.50(f)(1) and the Medicare Marketing Guidelines so that marketing representatives are informed of prohibited activities. AHC must also develop procedures for performing ongoing monitoring of its sales representatives. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 10: Compliance Plan	Comprehensive Fraud and Abuse Plan - The Part D sponsor must have and implement a compliance plan that includes a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse.	The comprehensive plan to detect, correct and prevent fraud, waste and abuse that AHC implemented in January 2007 is sufficient to meet this requirement. Therefore, no further corrective action is required.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Compliant Disenrollment Process - The MAO disenrolls Medicare members, when appropriate, upon receipt of a request for disenrollment. The MAO annotates its own system and the CMS system with the correct disenrollment effective date.	AHC must develop and implement policies and procedures that clearly describe steps to determine whether an enrollee is eligible to disenroll. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Involuntary Disenrollment for Disruptive Behavior - The MAO may disenroll Medicare members for disruptive behavior only when their behavior is disruptive, unruly, abusive, or uncooperative to the extent that continuing membership seriously impairs the MAO's ability to furnish services to the member or other members. Disruptive behavior includes threats of violence by the member to employees of the MAO. The MAO disenrolls Medicare members for disruptive behavior only after serious efforts to resolve the problem, including the use of internal grievance procedures, consideration of extenuating circumstances, and CMS's advance approval of the proposed disenrollment, have been made. Disenrollment of a member is effective the first day of the calendar month after the month in which notice is provided to the member of the intended action, unless otherwise determined by CMS.	AHC must revise its policies and procedures to clearly distinguish the responsibilities of each department in the process for involuntary disenrollment for disruptive behavior. Each policy must reference any other department and/or other policies related to this process. As a whole, all applicable policies must include all of the steps required by CMS prior to disenrollment for disruptive behavior. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.	AHC must develop and implement policies and procedures for identifying incomplete enrollment elections and requesting additional information to complete elections. AHC must also conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the training that it conducted, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. AHC must submit its plan for ongoing monitoring of this area to CMS.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.	AHC must submit to CMS a plan that will ensure that any denial letters will be sent within required timeframes.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 02 - Enrollment and Disenrollment	Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.	AHC must revise its policies and procedures to describe steps to be taken when CMS rejects enrollment due to coverage by a subsidized employer plan. Policies must reflect that all of the requirements in The Medicare Managed Care Manual Chapter 2 related to this deficiency will be met. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. AHC must submit its plan for ongoing monitoring of this area to CMS.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	AHC must revise its policies and procedures to monitor the marketing activities of its agents/brokers to ensure compliance with CMS requirements. These policies must include, at a minimum, procedures that detail how AHC will accomplish the following: -monitor the activities of individuals who sell its plans, -conduct regularly-scheduled personnel evaluations, -conduct ongoing training for individuals who sell its plans, and -withhold or withdraw payment if a beneficiary disenrolls shortly after enrolling in the plan AHC must submit these policies to CMS.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.	AHC must submit a plan detailing how it will correct the HSD tables to illustrate their actual provider network and submit this plan to CMS. The plan should contain an implementation timeline and a strategy for monitoring accuracy. Once the plan is approved by CMS and implemented, AHC must submit the new HSD tables to the regional office for review and approval. AHC must also submit their plan for securing a contract with Wuesthoff Medical Center and submit a copy of the cover and signature pages when a contract is obtained. AHC needs to submit their revised policy for standard drive time to network specialists.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	PCP Panel Established and Maintained - The MAO establishes, maintains, and monitors a panel of primary care providers from which the member may select a personal primary care provider.	AHC must provide CMS with corrected HSD tables, a current provider directory, and communication sent to members notifying them of changes to the PCP panel (additions and deletions). Once this information is received, CMS will determine the adequacy of the PCP panel. AHC must provide a corrective action for listing a PA as a PCP in the provider directory. AHC must provide the provider manual and revise its policies and procedures to specify who may serve as a PCP. Additionally, AHC must address instances in which ARNPs are included in the PCP panel.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Services Provided with Cultural Competence - The MAO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds.	AHC must obtain agreements for translator services and submit copies of those agreements to CMS.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Member Health Record Uses Established StandardsAll MAOs that offer CCPs must ensure that each provider furnishing services to members maintains member health records in accordance with standards established by the MAO, which take into account professional standards.	Pursuant to 42 CFR 422.112 (b)(4)(ii), AHC must ensure member health records are complete and information is current. The corrective action must include submitting revised policies and procedures and establishing a monitoring tool for assessing and improving the content and completeness of the members¿ records. AHC must submit its plan for ongoing monitoring of this area to CMS. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, AHC must provide CMS with a copy of the notification to physicians of these changes and the date that physicians are made aware of the changes.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 04 - Benefits and Beneficiary Protections	Initial Health Assessment ConductedThe MAO makes a good faith effort to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment.	AHC must begin immediately to conduct health assessments for new enrollees. AHC must provide CMS with a report of the new enrollees, the number of health assessments conducted and the number of unsuccessful attempts per month. AHC must submit this report on a quarterly basis for a minimum of two quarters.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	AHC must provide CMS with the following: - A 2007 QI Program and work plan that integrates all departments within the organization. The department responsible for each objective must be identified and quantifiable goals/measurements need to be documented. The QI Program also needs to identify why topics were selected and how goals/measurements were determined. - Signature pages showing the evaluation and work plan were approved by the COO and Medical Director - Copies of the QI Committee minutes, for a minimum of three quarters, that reflect implementation and progress of the 2006 work plan - Copies of the Board of Director Minutes that show when the program was reviewed and approved. - Copies of the Board of Director Minutes, for a minimum of two quarters, showing Board oversight of the QI program.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 05 - Quality Assurance	Adequate Health Information System - The MAO must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its QI program.	AHC must analyze their current claims processing system to identify and correct any areas that allow providers to submit inaccurate data. AHC must submit the results of this analysis along with the corrective action taken to CMS. AHC must develop a plan to identify and analyze reports to enable the QI and UM departments to track trends and benchmark data. The plan must include a timeline for implementation and a copy of all reports developed as part of the plan. AHC must submit a copy of this plan to CMS and indicate the individual responsible for data analysis. In addition, AHC must develop a plan to generate reports that identify over and underutilization, including a timeline for implementation. AHC must submit the plan to CMS with copies of the reports that are developed.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 05 - Quality Assurance	Significant Problems Corrected - The MAO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	AHC must develop a plan to ensure that that it corrects problems that it identifies during internal surveillance. The plan must include documentation showing the corrective action to be taken, the individual responsible for implementing and monitoring the corrective action, and the date the problem is corrected. The plan must describe how AHC will address the problems identified in the deficiency described above. AHC must submit this plan to CMS.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 05 - Quality Assurance	Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).	AHC must provide CMS with evidence that it has included in its written program an explanation about whether an ICD-9 code (or other data sources) are used as evidence of a comorbid condition versus a primary reason for CCIP eligibility. Documentation of this would enable reviewers to determine whether identification criteria are established and systematically utilized. In addition, AHC notes that using a broad criteria based on ICD-9 codes may result in false positives in diagnoses. As AHC further defines CCIP eligibility criteria, it must provide evidence that it prevents or at least accounts for the impact of false positives on outcomes measures, especially in regard to any future determination of cost outcomes. AHC must provide CMS with design processes for outcome measures that have been revised to reflect all aspects of the CCIP (both disease management and the Health and Wellness program). AHC must also provide evidence that it has sought out educational offerings and reports on strategies for evaluating outcomes. In addition, AHC must provide clarification about why the number of enrollees it says are eligible for the CCIP exceeds AHC's total enrollment by over 6,000 enrollees.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 05 - Quality Assurance	Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.	With regard to all three projects, AHC must: 1) Review the guides and manuals available on the CMS website health plans page, 2) Review the Medicare Managed Care Manual - Chapter 5: Quality Assessment and Improvement, 3) Review the HEDIS Technical Specifications, Volume 2 and indicators available from other national organizations, such as AHRQ, NQF, etc., 4) Seek training in quality improvement methods from the State QIO, NCQA, IHI or other local or national quality improvement organizations, and 5) Evaluate the documentation submitted for these projects and provide CMS with an action plan, including seeking technical assistance to reimplement the projects and submit a revised report. See the attached reports for each project from the MAQROs for additional comments and recommendations.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	AHC must submit revised ancillary provider policies and procedures, including the policy and procedure for delegated entities, to CMS for approval. Specifically, AHC must develop and submit an action plan for credentialing and recredentialing ancillary providers currently in the network, including a timeline for completion. Once the delegated entity policies and procedures are approved by CMS and AHC, AHC must provide them to Psychcare. AHC must also develop an appropriate audit tool and use it to monitor procedures. AHC must submit the plan and timeline to CMS and provide quarterly reports outlining the number of facilities credentialed and or recredentialed. AHC provide CMS with a description of how it will monitor compliance and the person/position responsible.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	AHC must revise all existing contracts with providers and delegated entities to add the 10-year record retention contract provision. In addition, AHC must develop and implement policies and procedures which detail how it will ensure that it amends new and existing contracts with any new CMS and Federal requirements. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 11 - Contracts	Adequate Compliance PlanThe MAO must have a formalized compliance plan that contains the requirements specified by CMS	AHC must provide a revised compliance program which includes methods for assessing areas at risk for noncompliance which AHC will subsequently target for internal auditing and monitoring.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	AHC must conduct training of appropriate staff on processes related to documenting all incoming grievances and notifying members about grievance resolutions. AHC must submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	AHC must conduct training of appropriate staff on the following topics: 1) When it is appropriate to advise the member of his or her right to receive a detailed written notice of a practitioner's decision not to provide a health service, and 2) Notifying members of the resolution of their grievances. AHC must submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must submit a grievance resolution notice template that includes the member's right to file a written complaint with the QIO if their grievance involves a quality of care complaint. AHC must submit the template through tne normal CMS marketing review process and provide evidence that it has done so for the purpose of this corrective action.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	AHC must conduct training of appropriate staff on notifying members of the resolution of their grievances and thoroughly documenting this activity. AHC must submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	AHC must conduct additional training of appropriate staff on how to develop claims from non-participating providers for which no authorization is on file. AHC must submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must continue to conduct an internal audit each month of this area to evaluate whether claims are being developed correctly. AHC must submit a summary report of its monthly findings to CMS once a quarter until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	AHC must implement changes to its enrollment and claim systems which will enable them to capture coordination of benefits information and Medicare secondary payer information that can be utilized by both the Claims and Enrollment Departments. AHC must also develop and implement policies and procedures for this area based upon any new system or updates of its existing claims and enriollment systems. AHC must conduct training of appropriate staff on the system enhancement and policies, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	AHC must establish a means for accurately documenting the receipt date of referral requests. Adequate documentation could include date-stamped correspondence, hand-written logs of referral requests that are recorded at the time a verbal request is made, or screen prints of phone logs showing the date that AHC received the request for service. AHC must revise its policies and procedures to reflect this means of documentation. AHC must conduct monthly audits to ensure appropriate documentation of the date of referral requests and the entry of this information into the data system. AHC must provide CMS with quarterly summary reports of its monthly audit results until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit. AHC must conduct training of appropriate staff on revised policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	AHC must revise its policies and procedures to include steps and/or examples of service descriptions and denial reasons which meet CMS requirements. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Organization Determination Requests - The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.	AHC must establish a means for accurately documenting the receipt date of referral requests. Adequate documentation could include date-stamped correspondence, hand-written logs of referral requests that are recorded at the time a verbal request is made, or screen prints of phone logs showing the date that AHC received the request for service. AHC must revise its policies and procedures to reflect this means of documentation. AHC must conduct monthly audits to ensure appropriate documentation of the date of referral requests and the entry of this information into the data system. AHC must provide CMS with quarterly summary reports of its monthly audit results until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit. AHC must conduct training of appropriate staff on revised policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	AHC must establish a means for accurately documenting the receipt date of referral requests. Adequate documentation could include date-stamped correspondence, hand-written logs of referral requests that are recorded at the time a verbal request is made, or screen prints of phone logs showing the date that AHC received the request for service. AHC must revise its policies and procedures to reflect this means of documentation. AHC must conduct monthly audits to ensure appropriate documentation of the date of referral requests and the entry of this information into the data system. AHC must provide CMS with quarterly summary reports of its monthly audit results until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit. AHC must conduct training of appropriate staff on revised policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	AHC must revise its policies and procedures to include steps and/or examples of service descriptions and denial reasons which meet CMS requirements. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	AHC must establish a means for accurately documenting the receipt date of referral requests. Adequate documentation could include date-stamped correspondence, hand-written logs of referral requests that are recorded at the time a verbal request is made, or screen prints of phone logs showing the date that AHC received the request for service. AHC must revise its policies and procedures to reflect this means of documentation. AHC must conduct monthly audits to ensure appropriate documentation of the date of referral requests and the entry of this information into the data system. AHC must provide CMS with quarterly summary reports of its monthly audit results until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit. AHC must conduct training of appropriate staff on revised policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	AHC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. This plan must provide assurance that AHC staff will maintain proper documentation of both verbal and written appeals in member files. AHC must submit the plan to CMS.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Reconsideration Requests - The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.	AHC must revise policies and procedures to add steps for documenting all oral expedited reconsideration requests in writing. AHC must also conduct training of appropriate staff on the revised policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	AHC must revise policies and procedures to add a provision for forwarding reconsideration cases to the Independent Review Entity (IRE) when AHC makes an adverse decision. AHC should also reference its policy APP-0004 in this policy. AHC must also conduct training of appropriate staff on the revised policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	AHC must submit a revised notice template which contains only language that is appropriate for this requirement. AHC must submit this template through the normal CMS marketing material review process, and provide evidence that this was done. AHC must also conduct training of appropriate staff on the revised template and submit documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	AHC must revise its policies and procedures to include the following: - a provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization tools to a drug, at least 60 days prior to the date the change becomes effective, and - a description of the method(s) used to provide notification of formulary changes. Notificiation method(s) must include, at a minimum, posting formulary changes on each affected plan's Internet website. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	AHC must revise its policies and procedures to include the following: - a requirement that any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, - a requirement that all persons marketing on behalf of the sponsor be state licensed, certified or registered individuals, and - a requirement that all persons marketing on behalf of the Part D sponsor be state licensed, certified or registered individuals. AHC must provide CMS with evidence that its marketing program monitoring activities confirm that AHC's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. AHC must also provide CMS with evidence that it has a current compensation structure in effect that includes the following: 1) a provision requiring the marketing representative to disclose to a potential beneficiary that the representative may be compensated based on the potential enrollee's enrollment in a plan, and 2) a provision prohibiting payment by a marketing representative to beneficiaries.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	AHC must revise its policies and procedures to include the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (1) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (2) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.	AHC must revise its policies and procedures to include a provision which reflects that it meets this requirement. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	AHC must revise its policies and procedures to include the following, in accordance with CMS requirements: - Procedures for providing a notice of "maintenance" formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, - Procedures for providing a notice of "other" formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, and - a description of the method used to provide notification of formulary changes. Notification must include, at a minimum, posting formulary changes on each affected plan's internet website. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	AHC must revise its policies and procedures to include the required provisions. America's Health Choice must provide CMS with system reports regarding its transition process utilization for LTC residents to verify that AHC correctly implements the transition process for LTC residents as described in its SOP and consistent with its contractual requirements.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	AHC must provide CMS with documentation that demonstrates that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	AHC must revise its policies and procedures for tracking and addressing redeterminations to include provisions for ensuring that it addresses requests for redeterminations and responds to them in a timely manner. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must provide CMS with a CMS-approved notice template for enrollee notification when a request for coverage determination concerning drug benefit is forwarded to the IRE. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	AHC must provide CMS with a CMS-approved notice template for enrollee notification when it forwards a request for coverage determination concerning payment to the IRE. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. AHC must revise its policies and procedures to include provisions for ensuring that it notifies enrollees of coverage determinations in a timely manner, and that it documents the dates on which it makes those notifications. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	AHC must provide CMS with a CMS-approved notice template for notifying enrollees of an adverse coverage determination. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. AHC must conduct training of appropriate staff on providing the notice to enrollees and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination - The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	AHC must revise its policies and procedures to include the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination - If the Part D sponsor decides not to expedite a coverage determination, it must automatically transfer the request to the standard timeframe, provide prompt oral notice to the enrollee and prescribing physician of the decision not to expedite, and provide equivalent written notice within 3 calendar days of the oral notice.		Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	AHC must provide CMS with a CMS-approved notice template for notifying enrollees when it denies an expedited coverage determination. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must revise its policies and procedures for Expedited Coverage Determination and Notice Requirement Timeframes (3024.pdf) to include the required provision and to ensure that it documents notification dates. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS with a CMS-approved notice template for enrollee notification when an expedited coverage determination is forwarded to the IRE. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	AHC must revise its policies and procedures for Expedited Coverage Determination and Notice Requirement Timeframes (3024.pdf) to include all of the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, AHC must provide CMS with a CMS-approved notice template for notifying enrollees of an adverse expedited coverage determination. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	AHC must revise its policies and procedures entitled Requesting Additional Information Timeframes (3027.pdf), Tiering Exceptions (3036.pdf), and Exceptions Process General (3038.pdf) to include required provisions. AHC must include the provisions in all three of these policies, with one exception. AHC does not need to include the provision to grant a tiering exception when the preferred drug would not be as effective as the requested drug and/or would have adverse effects in the policy Requesting Additional Information Timeframes (3027.pdf). AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, AHC must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	AHC must revise its policies and procedures entitled Requesting Additional Information Timeframes (3027.pdf), Exceptions Process (Non-formulary drug) (3026.pdf), and Exceptions Process General (3038.pdf) to include the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, AHC provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	AHC must revise its policies and procedures entitled Tiering Exceptions (3036.pdf) to clarify its policies for granting tiering exceptions for brand name drugs in accordance with CMS requirements and statements made during staff discussions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	AHC must revise its grievance policies and procedures to include the following provisions: - Promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals, and - Informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures and demonstrating that it has a means for informing enrollees of complaint categorization (e.g., phone script and notice template). AHC must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	AHC must revise its policies and procedures entitled Grievance Data Collection and Reporting (GRV-0004) to include the Part D reporting requirements. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must update its grievance tracking system to ensure that it tracks and addresses the timely resolution of grievances, and to ensure that it tracks the minimum information required.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	AHC must provide CMS with documentation which demonstrates that it has the formal bi-annual training program described in its grievance policies and procedures. Documentation should include the materials used in the training program, the individuals who conduct the training, and the staff who are trained.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	AHC must revise its policies and procedures to include the following provisions: - Extending the grievance resolution timeframe by 14 days or less if the enrollee requests the extension or if the AHC justifies a need for additional information and documents how the delay is in the interest of the enrollee, - Notifying the enrollee immediately in writing when AHC extends the deadline for grievance resolution, - Recording the date that AHC notified the enrollee of the grievance disposition, and - Notifying all concerned parties of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but not later than 30 days after the Sponsor receives the grievance. AHC must conduct training of Customer Service, Grievance, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS with a CMS-approved notice to inform enrollees in all cases where the Sponsor extends the grievance deadline. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	AHC must revise its grievance policies and procedures to include provisions for the following: - Responding in writing to all grievances that are submitted in writing and whenever the enrollee requests a written response, and - Recording the method of member notification of the grievance disposition. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS with a CMS-approved notice to inform enrollees of grievance disposition when written notice is required. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	AHC must revise its policies and procedures to include provisions for responding in writing to all grievances that are related to quality of care, regardless of how the grievance is filed. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must also provide CMS with a CMS-approved notice to inform enrollees of grievance disposition when written notice is required. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	AHC must revise its policies and procedures entitled Grievance Procedures (Grievance.pdf) and Request for Urgent Grievance Review (GA25-0004) to include Part D terminology and CMS requirements for timely response to expedited grievances. Specifically, policies and procedures must contain provisions for allowing a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by AHC to grant a request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	AHC must revise its policies and procedures entitled Coverage Determinations (3022.pdf) to include a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. AHC must also update its policies and procedures for tiering exceptions (3036.pdf) to include a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. In lieu of making these updates to these two documents, AHC may remove the discussion of expedited redeterminations from both of them, as it is outside of their title scope. CMS expects AHC to have one complete policy and procedure document for accepting requests for expedited redeterminations that its staff can reference. AHC must also revise its policies and procedures entitled Expedited Redeterminations (3003.pdf) to include the following: - The name of a designated office and/or department to receive both oral and written requests for expedited redeterminations, including a telephone number for oral requests. These policies and procedures may also include a facsimile number to facilitate receipt of requests for expedited redeterminations. - A provision for maintaining documentation of each expedited redetermination request in a case file. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	AHC must revise its policies and procedures entitled Expedited Redeterminations (3003.pdf) to include the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, AHC must provide CMS with a CMS-approved notice template for notifying an enrollee that a request for an expedited redetermination is denied. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to include the required provision. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must also provide the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. AHC must conduct training of appropriate staff on the timely notification and effectuation of standard redeterminations concerning covered drug benefits (e.g., as expeditiously as as the enrollee's health condition requires, but no later than 7 calendar days from the date it received the request). AHC must submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CMS may later request that AHC resubmit case files that demonstrate that it is in compliance with this requirement.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to include the required provision. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to state that it must inform the enrollee, within 24 hours, when his/her expedited redetermination case is forwarded to the IRE due to AHC's failure to notify the enrollee of a decision within the required timeframe. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must also provide the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	AHC must provide documentation that demonstrates that it uses appropriate personnel to conduct redeterminations. AHC must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, AHC must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician. CMS may request additional sample cases to determine that AHC is in compliance with this requirement.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	AHC must provide CMS with the required CMS-approved notice template. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	AHC must provide CMS with the required CMS-approved notice template. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA-PD	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	AHC stated that it did not have any third party reversals of cases of expedited determination or expedited redetermination for benefits during the audit period. Therefore, there are no cases for worksheet WS-RE3_D that apply to this element.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 02: Provider Communication	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to all authorized prescribers, network pharmacies, and pharmacists prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to all authorized prescribers, network pharmacies, and pharmacists.	AHC must revise its policies and procedures to include the following: - a provision to notify authorized prescribers, network pharmacies, and pharmacists of negative formulary changes, which are defined as assigning a higher cost sharing to a drug, removing a drug from the sponsor's formulary, or adding utilization tools to a drug, at least 60 days prior to the date the change becomes effective, and - a description of the method(s) used to provide notification of formulary changes. Notificiation method(s) must include, at a minimum, posting formulary changes on each affected plan's Internet website. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.	AHC must revise its policies and procedures to include the following: - a requirement that any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, - a requirement that all persons marketing on behalf of the sponsor be state licensed, certified or registered individuals, and - a requirement that all persons marketing on behalf of the Part D sponsor be state licensed, certified or registered individuals. AHC must provide CMS with evidence that its marketing program monitoring activities confirm that AHC's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. AHC must also provide CMS with evidence that it has a current compensation structure in effect that includes the following: 1) a provision requiring the marketing representative to disclose to a potential beneficiary that the representative may be compensated based on the potential enrollee's enrollment in a plan, and 2) a provision prohibiting payment by a marketing representative to beneficiaries.	Closed

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America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 03: Marketing and Beneficiary Information	Provision of Notices Regarding Formulary Changes - Prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug, the Part D sponsor must provide a written notice to affected enrollees at least 60 days prior to the date the change becomes effective, or provide such enrollee with a 60 day supply of the Part D drug under the same terms as previously allowed, and written notice of the formulary change at the time an affected enrollee requests a refill of the Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the affected enrollees.	AHC must revise its policies and procedures to include the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 06: Pharmacy Access	Access to Long-Term Care Pharmacies - The Part D sponsor must offer standard contracting terms and conditions, including performance and service criteria, to all long-term care (LTC) pharmacies in its Part D plan service area. The Part D sponsor must contract with a sufficient number of LTC pharmacies to provide all of its plans¿ institutionalized enrollees convenient access to their Part D benefits.	AHC must revise its policies and procedures to include a provision which reflects that it meets this requirement. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Provision of Notice Regarding Formulary Changes - The Part D sponsor must provide at least 60 days notice to CMS, State Pharmaceutical Assistance Programs (SPAPs), and entities providing other prescription drug coverage prior to removing a covered Part D drug from its formulary or making any changes to the preferred or tiered cost-sharing status of a covered Part D drug. If the change involves immediate removal of a Part D drug deemed unsafe by the Food and Drug Administration (FDA) or removed from the market by the manufacturer, the Part D sponsor must provide retrospective notice to the parties listed above.	AHC must revise its policies and procedures to include the following, in accordance with CMS requirements: - Procedures for providing a notice of "maintenance" formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, - Procedures for providing a notice of "other" formulary changes to CMS, SPAPS, and entities providing other prescription drug coverage, and - a description of the method used to provide notification of formulary changes. Notification must include, at a minimum, posting formulary changes on each affected plan's internet website. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 07: Formulary, Transition Process, and Pharmacy and Therapeutics Committee	Transition Process for Residents of Long-Term Care Facilities - The Part D sponsor must have and implement an appropriate transition process in accordance with CMS requirements for addressing the unique needs of long-term care (LTC) facility residents prescribed Part D drugs that are not on its formulary or that are on its formulary but require prior authorization or step therapy.	AHC must revise its policies and procedures to include the following: - a requirement for addressing the immediate needs of long-term care (LTC) beneficiaries and timeframes to ensure a seamless transition for LTC facility residents, and - a provision to abide by extensions to the transition period in accordance with CMS policy. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must submit system reports regarding its transition process utilization for LTC residents to demonstrate that it correctly implements the transition process for LTC residents as described in its policies and procedures and consistent with its contractual requirements.	Closed

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America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 11: First-Tier and Downstream Contracts / Maintenance of Records	Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies.	AHC must provide CMS with a copy of the contract that it could not locate. AHC must also amend its long-term contract addenda to include a provision to require the pharmacy to provide price differential information to Part D plans for inclusion in the written Explanation of Benefits. AHC must provide a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.	AHC must provide CMS with documentation that demonstrates that its network pharmacies are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. An example of acceptable documentation for this is results of pharmacy audits showing the number and percent of pharmacies that have undergone audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.	AHC must revise its policies and procedures for tracking and addressing redeterminations to include provisions for ensuring that it addresses requests for redeterminations and responds to them in a timely manner. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must provide CMS with a CMS-approved notice template for enrollee notification when a request for coverage determination concerning drug benefit is forwarded to the IRE. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.	AHC must provide CMS with a CMS-approved notice template for enrollee notification when it forwards a request for coverage determination concerning payment to the IRE. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. AHC must revise its policies and procedures to include provisions for ensuring that it notifies enrollees of coverage determinations in a timely manner, and that it documents the dates on which it makes those notifications. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Denial Notice Requirements for Coverage Determinations - If the Part D sponsor makes an adverse determination, in whole or in part, it must provide the enrollee with written notification, using approved notice language that is readable and understandable, states the specific reasons for the denial, and informs the enrollee of his or her right to a redetermination.	AHC must provide CMS with a CMS-approved notice template for notifying enrollees of an adverse coverage determination. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. AHC must conduct training of appropriate staff on providing the notice to enrollees and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Decision to Accept or Deny Request for Expedited Coverage Determination; The Part D sponsor must promptly and correctly determine whether a complaint is a standard coverage determination or an expedited coverage determination. The Part D sponsor must have a means for issuing prompt decisions on expediting a coverage determination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a coverage determination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.	AHC must revise its policies and procedures to include the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination - The notice for the decision to deny a request for an expedited coverage determination must provide an explanation that the Part D sponsor must process the request using the 72 hour timeframe for standard determinations; inform the enrollee of the right to file an expedited grievance; inform the enrollee of the right to resubmit a request for an expedited determination with the prescribing physician¿s support; and provide instructions about the Part D plan¿s grievance process and its timeframes.	AHC must provide CMS with a CMS-approved notice template for notifying enrollees when it denies an expedited coverage determination. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must revise its policies and procedures for Expedited Coverage Determination and Notice Requirement Timeframes (3024.pdf) to include the required provision and to ensure that it documents notification dates. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS with a CMS-approved notice template for enrollee notification when an expedited coverage determination is forwarded to the IRE. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.	AHC must revise its policies and procedures for Expedited Coverage Determination and Notice Requirement Timeframes (3024.pdf) to include all of the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, AHC must provide CMS with a CMS-approved notice template for notifying enrollees of an adverse expedited coverage determination. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	AHC must revise its policies and procedures entitled Requesting Additional Information Timeframes (3027.pdf), Tiering Exceptions (3036.pdf), and Exceptions Process General (3038.pdf) to include required provisions. AHC must include the provisions in all three of these policies, with one exception. AHC does not need to include the provision to grant a tiering exception when the preferred drug would not be as effective as the requested drug and/or would have adverse effects in the policy Requesting Additional Information Timeframes (3027.pdf). AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, AHC must provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.	AHC must revise its policies and procedures entitled Requesting Additional Information Timeframes (3027.pdf), Exceptions Process (Non-formulary drug) (3026.pdf), and Exceptions Process General (3038.pdf) to include the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, AHC provide CMS with a CMS-approved notice template for requesting additional information from the enrollee's prescribing physician. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Approval of Tiering and Non-Formulary Exceptions Requests - Following approval of a request for a tiering or a non-formulary exception, the Part D sponsor cannot require an approval for a refill or a new prescription following the initial prescription, provided that (i) the enrollee¿s prescribing physician continues to prescribe the drug; (ii) the drug continues to be considered safe for treating the enrollee¿s disease or medical condition; and (iii) the enrollment period has not expired. For tiering exceptions, the Part D sponsor must permit enrollees to obtain an approved non-preferred drug at the more favorable cost-sharing terms applicable to drugs in the preferred tier. For approved non-formulary exceptions, the Part D sponsor has the flexibility to determine what level of cost-sharing applies to all non-formulary drugs approved under the exceptions process, so long as the designated level is one of its existing cost-sharing tiers.	AHC must revise its policies and procedures entitled Tiering Exceptions (3036.pdf) to clarify its policies for granting tiering exceptions for brand name drugs in accordance with CMS requirements and statements made during staff discussions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.	AHC must revise its grievance policies and procedures to include the following provisions: - Promptly and correctly categorizing complaints as inquiries, grievances, or coverage determinations/appeals, and - Informing enrollees whether their complaints are subject to grievance procedures or coverage determination procedures and demonstrating that it has a means for informing enrollees of complaint categorization (e.g., phone script and notice template). AHC must conduct training of its Customer Service staff, Grievance staff, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS with a CMS-approved notice to inform enrollees about inquiries involving excluded drugs. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.	AHC must revise its policies and procedures entitled Grievance Data Collection and Reporting (GRV-0004) to include the Part D reporting requirements. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must update its grievance tracking system to ensure that it tracks and addresses the timely resolution of grievances, and to ensure that it tracks the minimum information required.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.	AHC must provide CMS with documentation which demonstrates that it has the formal bi-annual training program described in its grievance policies and procedures. Documentation should include the materials used in the training program, the individuals who conduct the training, and the staff who are trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.	AHC must revise its policies and procedures to include the following provisions: - Extending the grievance resolution timeframe by 14 days or less if the enrollee requests the extension or if the AHC justifies a need for additional information and documents how the delay is in the interest of the enrollee, - Notifying the enrollee immediately in writing when AHC extends the deadline for grievance resolution, - Recording the date that AHC notified the enrollee of the grievance disposition, and - Notifying all concerned parties of grievance disposition as expeditiously as the enrollee's case requires, based on the enrollee's health status, but not later than 30 days after the Sponsor receives the grievance. AHC must conduct training of Customer Service, Grievance, and any other appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS with a CMS-approved notice to inform enrollees in all cases where the Sponsor extends the grievance deadline. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Method of Grievance Response - The Part D sponsor must respond to all written grievances in writing (including facsimile). If the enrollee orally submits a grievance and requests a written response, the Part D sponsor must respond in writing.	AHC must revise its grievance policies and procedures to include provisions for the following: - Responding in writing to all grievances that are submitted in writing and whenever the enrollee requests a written response, and - Recording the method of member notification of the grievance disposition. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS with a CMS-approved notice to inform enrollees of grievance disposition when written notice is required. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Grievance Response ¿ Quality of Care - The Part D sponsor must respond in writing to all grievances related to the quality of care. The response must include a description of the enrollee¿s right to file a written complaint with the Quality Improvement Organization (QIO). If a complaint is submitted to the QIO, the Part D sponsor must cooperate with the QIO in resolving the complaint.	AHC must revise its policies and procedures to include provisions for responding in writing to all grievances that are related to quality of care, regardless of how the grievance is filed. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must also provide CMS with a CMS-approved notice to inform enrollees of grievance disposition when written notice is required. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.	AHC must revise its policies and procedures entitled Grievance Procedures (Grievance.pdf) and Request for Urgent Grievance Review (GA25-0004) to include Part D terminology and CMS requirements for timely response to expedited grievances. Specifically, policies and procedures must contain provisions for allowing a 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by AHC to grant a request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Request for Redeterminations (Expedited) - The Part D sponsor must establish and maintain an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must provide the enrollee or the prescribing physician with a reasonable opportunity to present in person or in writing evidence and allegations of fact or law related to the issue in dispute. S ince the opportunity to submit evidence is limited, the Part D sponsor must inform the enrollee or the prescribing physician of the conditions for submitting such evidence.	AHC must revise its policies and procedures entitled Coverage Determinations (3022.pdf) to include a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. AHC must also update its policies and procedures for tiering exceptions (3036.pdf) to include a provision for maintaining an efficient and convenient means for an enrollee or a prescribing physician acting on behalf of an enrollee to submit oral or written requests for expedited redeterminations. In lieu of making these updates to these two documents, AHC may remove the discussion of expedited redeterminations from both of them, as it is outside of their title scope. CMS expects AHC to have one complete policy and procedure document for accepting requests for expedited redeterminations that its staff can reference. AHC must also revise its policies and procedures entitled Expedited Redeterminations (3003.pdf) to include the following: - The name of a designated office and/or department to receive both oral and written requests for expedited redeterminations, including a telephone number for oral requests. These policies and procedures may also include a facsimile number to facilitate receipt of requests for expedited redeterminations. - A provision for maintaining documentation of each expedited redetermination request in a case file. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.	Closed

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America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Actions Following Decision to Deny Request for Expedited Redetermination - If the Part D sponsor denies a request for an expedited redetermination, it must automatically transfer the request to the standard redetermination timeframe, provide prompt oral notice to the enrollee, according to CMS requirements, and provide equivalent written notice within 3 calendar days of the oral notice.	AHC must revise its policies and procedures entitled Expedited Redeterminations (3003.pdf) to include the required provisions. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, AHC must provide CMS with a CMS-approved notice template for notifying an enrollee that a request for an expedited redetermination is denied. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to include the required provision. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must also provide the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit. AHC must conduct training of appropriate staff on the timely notification and effectuation of standard redeterminations concerning covered drug benefits (e.g., as expeditiously as as the enrollee's health condition requires, but no later than 7 calendar days from the date it received the request). AHC must submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. CMS may later request that AHC resubmit case files that demonstrate that it is in compliance with this requirement.	Closed

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America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to include the required provision. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must provide CMS the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.	AHC must revise its policies and procedures entitled Failure to Meet Timeframes (Standard and Expedited Redeterminations) (3006.pdf) to state that it must inform the enrollee, within 24 hours, when his/her expedited redetermination case is forwarded to the IRE due to AHC's failure to notify the enrollee of a decision within the required timeframe. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must also provide the required CMS-approved notice templates. If AHC does not have notice templates that have been approved by CMS, then it must submit them for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

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America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.	AHC must provide documentation that demonstrates that it uses appropriate personnel to conduct redeterminations. AHC must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, AHC must ensure that the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician. CMS may request additional sample cases to determine that AHC is in compliance with this requirement.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	AHC must provide CMS with the required CMS-approved notice template. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	AHC must provide CMS with the required CMS-approved notice template. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed
America's Health Choice Medical Plans, Inc		S9086 (Termination)	Part D	Audit Findings	3/13/2007	Closed	Chapter 13: Grievances, Coverage Determinations, and Appeals	Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.	AHC must provide the required CMS-approved notice template. If AHC does not have a notice template that has been approved by CMS, then it must submit one for CMS approval through the normal marketing review submission process, and provide evidence that it has done this for the purpose of this audit.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
America's Health Choice Medical Plans, Inc		H1034 (Termination)	MA	Audit Findings	3/13/2007	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	In order to demonstrate compliance with Credentialing Requirements for Physicians and Other Health Care Professionals, America's Health Choice must establish a Quality Improvement process which encompasses a formal process for reviewing performance indicators including: utilization management system, grievance system, enrollee satisfaction surveys, and other activities of the organization. America's Health Choice credentialing staff must ensure that all provider applications are completed in entirety in order to demonstrate compliance with CMS requirements. In addition to ensuring completed applications, the America's Health Choice credentialing staff must verify that the information on the application, including the Attestation page, correlates with the information provided by the Primary Verification Source.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Current guidelines state that the MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay. Therefore it is our recommendation that Mapfre re-educate staff and modify its Policy and Procedures to ensure that the organization is in compliance with Grievance Decision Notification (Timeliness) guidelines as outlined in Section 13 of the Medicare Managed Care Manual.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Current guidelines state that the MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay. Therefore it is our recommendation that Mapfre re-educate staff and modify its Policy and Procedures to ensure that the organization is in compliance with Grievance Decision Notification (Timeliness) guidelines as outlined in Section 13 of the Medicare Managed Care Manual.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	Mapfre must ensure that the Claims Department exhausts all options in your attempts to secure information necessary to properly develop a claim prior to denial. This requirement must be documented and supported by policy and procedures.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Mapfre must ensure that its claims department process and pay all clean claims within 30 days of receipt of said claim. In the event the claim is not paid within 30 days then the organization must pay interest on the claim, based upon the federal rates in effect at the time of the event.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	Mapfre must ensure that its claims department process and pay all clean claims within 30 days of receipt of said claim. In the event the claim is not paid within 30 days then the organization must pay interest on the claim, based upon the federal rates in effect at the time of the event.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	In order to guarantee that they satisfy compliance requirements Mapfre must ensure that they adhere to the timeframes established for processing claims as annotated below: -Clean Non-participating provider claims must be processed and paid within 30 days of receipt of completed claim. In the event the claim is not processed within 30 days plan must pay interest on claim. - Non-clean Non-participating provider claims must be processed, paid or denied within 60 days of receipt of the claim.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	In the event Mapfre denies payment for a service in whole or in part, the organization must issue an OMB approved Notice of Denial Payment, (CMS-10003-Notice of Denial of Payment (NDP)) to the beneficiary within 60 days of receiving the request for payment. The notice shall provide the beneficiary with the name of the provider, date and type of service and basis for denial. Mapfre must ensure that its claims department adheres to these instructions and that they are reflected in policy and procedure manuals.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	In the event Mapfre denies a members request for a service in whole or in part, the organization must issue an OMB approved CMS-10003-NDMC (Notice of Denial of Medical Coverage) to the beneficiary as expeditiously as the enrollee's health requires but no later than 14 days of receiving the request for decision. The notice shall provide the beneficiary with the name of the provider, date and type of service and basis for denial. Mapfre must ensure that its Utilization review department adheres to these instructions and that they are reflected in policy and procedure manuals.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	In the event Mapfre denies a members request for a service in whole or in part, the organization must issue an OMB approved CMS-10003-NDMC (Notice of Denial of Medical Coverage) to the beneficiary as expeditiously as the enrollee¿s health requires but no later than 14 days of receiving the request for decision. The notice shall provide the beneficiary with the name of the provider, date and type of service and basis for denial. Mapfre must ensure that its Utilization review department adheres to these instructions and that they are reflected in policy and procedure manuals.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	Mapre must develop and document internal policy and procedures, which provides individuals responsible for receiving, acknowledging and processing Expedited Organization Determinations, with detailed instructions on how to execute and disseminate decisions in accordance with Medicare Guidelines. In addition to the implementation of staff training and policy and procedure updates, Mapfre must also submit to the Regional office quarterly reports of Requests for expedited Organization determinations.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Mapre must develop and document internal policy and procedures, which provides individuals responsible for receiving, acknowledging and processing Expedited Organization Determinations, with detailed instructions on how to execute and disseminate decisions in accordance with Medicare Guidelines. In addition to the implementation of staff training and policy and procedure updates, Mapfre must also submit to the Regional office quarterly reports of Requests for expedited Organization determinations.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	Mapfre must ensure that all extensions are proper, appropriately documented and written notifications are sent to the member. Mapfre must train its Appeals and Grievance staff and update its policies and procedures to support this requirement.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	Although this element could not be validated during inspection of the cases files, it was determined, after the interviews with staff and review of the policies and procedures, that Mapfre does have a process in place for transferring expedited cases to the standard process when appropriate.	Closed

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MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	Mapre must develop and document internal policy and procedures, which provides individuals responsible for receiving, acknowledging and processing Expedited Organization Determinations, with detailed instructions on how to execute and disseminate decisions in accordance with Medicare Guidelines. In addition to the implementation of staff training and policy and procedure updates, Mapfre must also submit to the Regional office quarterly reports of Requests for expedited Organization determinations.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Mapfre must ensure that favorable claims reconsiderations are properly annotated in their systems and that statistical data pertaining to such cases can be easily accessed upon request.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	Mapfre must ensure that unfavorable claims reconsiderations are properly annotated in their systems and that statistical data pertaining to such cases can be easily accessed upon request.	Closed
MAPFRE PRAICO CORPORATION	1-787-250-6500 Ext. 6288	H5821	MA	Audit Findings	2/23/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	Mapfre must ensure that unfavorable claims reconsiderations are properly annotated in their systems and that statistical data pertaining to such cases can be easily accessed upon request.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 04 - Benefits and Beneficiary Protections	Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.	Elderplan needs to explore the option of a Transplant Network in order to assure that services are available to any member in need of a transplant.	Closed

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Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 04 - Benefits and Beneficiary Protections	No Member Discrimination in Delivery of Health CareThe MAO implements procedures to ensure that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.	Elderplan needs to update the Provider Manual to include the missing elements from the non-discrimination section of the Provider Manual. Indicate when the revision will be made, including how and when the current provider network will be informed of the change. Submit a copy of the revision to CMS.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 04 - Benefits and Beneficiary Protections	Member Health Record Uses Established StandardsAll MAOs that offer CCPs must ensure that each provider furnishing services to members maintains member health records in accordance with standards established by the MAO, which take into account professional standards.	Elderplan needs to update their policies and procedures for Medical Record Audits to include the required information and submit a copy of the revised policy and procedure to CMS. Indicate how and when the current provider network will be notified of the change in the way Medical Record Audits performed and provide a copy of the notification to CMS.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 05 - Quality Assurance	QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.	Elderplan must provide CMS with the following: -A copy their 2006 QI plan evaluation and 2007 Workplan that addressing the deficiencies outlined above. -Signature pages showing the evaluation and workplan were approved by the COO and Medical Director -Copies of the QI Committee minutes, for a minimum of three quarters, that reflect implementation and progress of the 2006 workplan -Copies of the Board of Director Minutes that show when the program was reviewed and approved. -Copies of the Board of Director Minutes, for a minimum of two quarters, showing Board oversight of the QI program. In addition, Elderplan must notify CMS when a Medical Director and QI Director are hired and provide copies of the nominees¿ resumes. Refer to QY05 and QY09	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 05 - Quality Assurance	Significant Problems Corrected - The MAO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	Elderplan must develop a formal process to identify, assess and prioritize problems using internal surveillance measures and integrate the results into the QI minutes for analysis and documentation of corrective actions to be taken on identified trends and problems. Elderplan must submit the developed process to CMS.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 05 - Quality Assurance	Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.	Elderplan needs to select a topic for their 2006 from the possible subjects presented to CMS during the monitoring audit. In addition to informing CMS of the subject, Elderplan must indicate how the topic was selected and the baseline data used.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	Elderplan must develop a strategy to correct the deficiencies addressed above. The strategy needs to include what changes will be made in auditing delegated entity credentialing/recredentialing and how the plan will monitor their own files to ensure that all files meet credentialing and recredentialing criterion. Include any timelines needed to accomplish objectives and submit copies to CMS.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 06 - Provider Relations	Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.	Elderplan must revise their policies and procedures to include all ancillary provider types. Elderplan must also develop a plan to determine which ancillary credentialing/recredentialing files are incomplete and how deficiencies in these files will be corrected, including a timeline for correction. Provide CMS with the revised policies and procedures and plan for file review and correction, including timeline.	Closed

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Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 06 - Provider Relations	Discrimination Against Health Care Professionals ProhibitedAn MAO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his/her license.	Elderplan needs to revise the Provider Manual to include the absent statement. Indicate when the revision will be made, including how and when the current provider network will be informed of the change. Submit a copy of the revision to CMS.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Elderplan had already taken action to remedy this deficiency before the end of the site visit. A provider contract addendum was being mailed to all network providers. The addendum updated the contracts to include the 10-year records retention requirement and the federal right to audit requirement. Providers rejecting the the addendum within the 30-day time limit (as per current contract provisions for contract amendments) would have 60 days to cure the problem or to leave the network. This corrective action plan should be formalized in writing, signed off by management, and be submitted through HPMS for acceptance by CMS. For the CAP to be released, Elderplan must evidence to CMS that the addendum was sent to network providers (include how many). Elderplan also needs to report which (if any) providers left the network because they refused to accept the addendum. If refusals to accept the addendum resulted in any critical gaps in the network, Elderplan should also report on how it has remedied any resulting network gaps.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 11 - Contracts	Required Contract Provisions for Deemable Activities: Delegation RequirementsThe MAO's written contracts with any entity that performs deemable activities that are delegated under its contract with CMS must contain provisions that specify that the entity adhere to the delegation requirements in the MA regulation.	Elderplan must formally recognize and document that it has delegated to IPAs and/or network hospitals its responsibility to bind downstream network providers (i.e., providers who are listed as network providers and are employed by or owned by the IPAs or hospitals) to meet applicable regulatory requirements through compliant contracts or agreements. Beyond the standard, delegated credentialling requirements, such regulatory requirements for contracts or agreements include Hold Harmless, Abide by Federal Requirements (including continuation of treatment, non-discrimination, honoring patient rights, retention of records, cooperation with Federal reviews or audits, etc.) and Compliance With the MAO's Policies and Procedures (including UM/UR, appeals and grievances, etc.). Elderplan must be able to demonstrate that its contracts with such IPAs or hospitals recognize the above by explicit statements in the contracts or contract amendments, or that the contracts reach to other documents that bind the IPAs or hospitals to perform this delegated responsibility. If Elderplan uses contractual reach to other documents, it must show that the IPAs or hospitals were formally made aware of the reach and the content of these documents containing this responsibility for downstream providers. Elderplan must document its monitoring and enforcement arrangements/processes for ensuring that such delegated entities legally and specifically bind the downstream providers to the applicable network provider requirements in the delegated entities' contracts/agreements with Elderplan. Elderplan must explain in a Plan of Correction when and how it will be able to demonstrate compliance with 422.506(i)(4) and (5) and 422.202(a) and (d) for downstream providers (as separately listed in HSD tables or in provider directories) who are IPA employed or are hospital employed or owned.	Closed

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Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Elderplan must ensure that grievances are processed within the mandated regulatory time-frames. It was noted that in a number of the cases which were non-compliant, the plan also failed to take an extension and the cases involved quality of care issues requiring contact with a physician. The corrective action plan should focus on training Elderplan's staff to recognize when a girevance investigation will take additional time to complete and issuing an extension to the complainant. Also when physician input is required in order to be responsive to enrollee issues, there should be an expedited follow up process to assure that physicians and the ir office staffs understand that a prompt response is required. Provider representatives should also stress this aspect in their contacts with physicians. Please provide a formalized corrective action plan to resolve this requirement with a training time table and plan for supervisory follow up.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Elderplan must submit a Corrective Action Plan (CAP) on how it will ensure that favorable claims reconsiderations are paid timely (i.e., within 60 days of receiving the request for reconsideration). The CAP must include how Elderplan will monitor and verify that favorable reconsiderations of claims are paid timely over at least two consecutive quarters. For the CAP to be released, Elderplan must present this verification to the CMS RO.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	Elderplan must submit a Corrective Action Plan (CAP) on how it will ensure that adverse claims reconsiderations are processed timely (i.e., within 60 days of receipt at the plan). This includes both forwarding the case to the IRE and notifying the member when Elderplan upholds its original determination. The CAP must include how Elderplan will monitor and verify that unfavorable reconsiderations of claims are forwarded timely to IRE and that members are notified timely over at least two consecutive quarters. For the CAP to be released, Elderplan must present this verification to the CMS RO.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	Elderplan must submit a corrective action plan on how it will ensure that unfavorable claims reconsiderations that are reversed (by Elderplan or by the IRE) are paid within 30 calendar days. The CAP must include how Elderplan will monitor and verify that reversed claims denials are paid timely. For the CAP to be released, Elderplan must present this verification to the CMS RO.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	Elderplan must ensure that pre-service reconsiderations are processed promptly. Staff should be given training in the reconsideration area to stress the importance of meeting federal time-frames.	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	Elderplan must ensure that appropriate case classification is carried out. Since the validity of data and compliance with processing requirements is dependent on correct case categorization, it is essential that this systems aspect be resolved. Elderplan staff should be given training to assure that future cases are classified properly. Elderplan must supply a new universe of cases that meet the definition of the universe (standard pre-service determinations that were not favorable to the member) and CMS must do a new worksheet WsRP2 as a later focused review of elements depending on that universe and worksheet (i.e., elements RP02 and RP03).	Closed
Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	Please cross reference to the Corrective Action Required for Element RP02.	Closed

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Metropolitan Jewish Health System (MJHS)	1-718-759-4458	H9101	MA	Audit Findings	1/22/2007	Open	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	Elderplan must ensure that staff are aware of federal time-frames and documentation requirements in processing expedited reconsiderations when such requests are received. This aspect should be included in appeal training for staff.	Closed
Lifetime Healthcare, Inc.	1-585-238-4545	H3351	MA	Audit Findings	1/12/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Excellus must ensure that the federal 10-year record retention requirement provision is specified in all contracts with Excellus/Univera (H3351) network providers. The CAP must specify how and when this will be accomplished.	Closed

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Lifetime Healthcare, Inc.	1-585-238-4545	H3351	MA	Audit Findings	1/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Excellus must ensure that grievance acknowledgement letters follow the required federal timeframes. A revised template letter should be prepared and also a template letter providing for extensions when appropriate. Staff should also be reminded that when a quality of care issue is noted in a grievance, there should also be a notice to the complainant of the right to file a written complaint with the QIO.	Closed
Lifetime Healthcare, Inc.	1-585-238-4545	H3351	MA	Audit Findings	1/12/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	Excellus must ensure that non-contracting providers' clean claims are paid timely. 95% of clean claims are required to be paid within 30 days of receipt. Excellus must submit a corrective action plan that will ensure that it processes non-participating providers' claims on a timely basis. The plan must include how it will monitor that non-participating provider claims are paid timely. For the CAP to be released, Excellus must demonstrate that at least 95% of the non-participating provider claims are paid within 30 days for 2 consecutive quarters. It could use the the CMS worksheet for this element on a random sample of at least 20 non-participating provider claims per quarter until it is successful.	Closed
Wellpoint, Inc.	1-303-831-2514	H3370	MA	Audit Findings	1/8/2007	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Empire must ensure that the federal 10-year record retention requirement provision is specified in all contracts with Senior Plan Direct (H3370) network providers. Prior to the CMS team departure from the onsite review, Empire staff presented an unsigned draft of the MAO's proposed corrective action plan for element CN04. The draft stated that Empire would treat this topic in near-term provider communication vehicles and that the provision would be included in a broader amendment to all provider contracts scheduled for 1st quarter of 2007. CMS finds this draft acceptable. It should be signed and approved by Empire management and be formally submitted as the CAP for this element.	Closed
Wellpoint, Inc.	1-303-831-2514	H3370	MA	Audit Findings	1/8/2007	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	Empire must ensure that Medicare grievance cases are processed in a timely manner in accordance with federal requirements and timeframes. Prior to the CMS team departure from the onsite review, Empire staff presented an unsigned draft of the MAO's proposed corrective action plan for element GV03 indicating that the Grievance and Appeal Coordinator would maintain a complaint tracking spreadsheet in order to assure that prompt follow up action is implemented to eliminate non-compliant trends. The proposed CAP also called for follow up by Provider Relations coodinators to impress on providers the need for a rapid response to enrollee quality of care complaints. CMS believes the proposed CAP responds to the review findings and suggests that it be signed and implemented.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H2408	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials - For "non-model" documents and for "model" documents that the M+CO modifies: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 45 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.For "model" documents that the M+CO uses without modification: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 10 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H2408	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H2408	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The M+CO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must develop and implement internal procedures to ensure that providers are not on the Medicare sanction or opt-out lists. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-936-3012	H2408	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Provider Payment Appeal System - M+C Private fee for service plans must establish and maintain a payment appeal system under which providers may have their payment claims reviewed in the event that a provider believes he was paid less than he would have been paid under Original Medicare. Providers must demonstrate that they have not received proper payment and the plan must then pay the difference between what the provider originally received and what he would have received under Original Medicare.	United must develop a payment appeal system under which providers may have their payment claims reviewed in the event that a provider believes he was paid less than he would have been paid under Original Medicare. Providers are required to demonstrate that they have not received proper payment and the plan must then pay the difference between what the provider originally received and what he would have received under Original Medicare. United must ensure that all providers have access to the procedures required under this process. In addition, United must develop internal procedures for processing these provider appeals and conduct training of appropriate staff. United must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must develop oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing these controls.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H2408	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Claim Denials (Notice Content) - If an M+CO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must develop and revise the free form text for denial notices to clearly state what service is being denied and the reason the service is being denied. In addition, the notices must clearly reflect when there is member liability. United must submit revised denial language to CMS for review and approval. United must improve oversight controls to ensure CMS compliance. United must submit a strategy to CMS detailing these controls.	Closed
UnitedHealth Group, Inc.	1-952-936-3012	H2408	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Payment rates under PFFS plan - M+CO must demonstrate to CMS that it has payment rates that are not less than the rates that apply under original Medicare for the provider in question.	United must develop internal procedures to include a process that makes sure the most current Medicare fee schedules are applied. United must conduct training for appropriate staff. United must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United must a strategy to CMS detailing these controls.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0319	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0319	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0319	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0319	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0319	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0319	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0319	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0620	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0620	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0620	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0620	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0620	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0620	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0620	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0710	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0710	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0710	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0710	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0710	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0710	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0710	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1108	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1108	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1108	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1108	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1108	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1108	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1108	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1303	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1303	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1303	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1303	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1303	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1509	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1509	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1509	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1509	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1509	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1717	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1717	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1717	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1717	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1717	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1717	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1717	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2001	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2001	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2001	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2001	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2001	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2001	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2001	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2003	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2003	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2003	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2003	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2003	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2003	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2003	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2111	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H2111	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2111	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2228	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H2228	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2228	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2228	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2228	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2228	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2228	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2406	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H2406	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2406	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3209	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3209	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3209	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3209	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3209	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3209	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3209	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3812	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3812	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3812	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3812	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3812	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3812	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3812	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3912	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3912	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3912	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3912	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3912	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3912	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3912	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3921	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3921	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3921	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3921	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3921	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3921	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3921	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4522	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4522	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4522	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4522	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4522	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4522	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4522	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5417	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5417	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5417	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5417	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5417	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5417	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5424	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H5424	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5424	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5424	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5424	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5424	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5424	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.		H5500 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.		H5500 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.		H5500 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.		H5500 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.		H5500 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5507	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5507	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5507	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5507	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5507	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5507	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5516	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5516	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5516	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
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UnitedHealth Group, Inc.		H5518 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.		H5518 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.		H5518 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.		H5518 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.		H5527 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.		H5527 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.		H5527 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.		H5527 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.		H5527 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.		H5527 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.		H5527 (Withdrawn Contract)	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5532	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5532	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5532	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5532	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	United must revise and provide to CMS internal policies and procedures to ensure that the United makes correct claims determinations for the product. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5532	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must revise and provide to CMS internal policies and procedures to ensure that free-form language in the standardized denial notice meets CMS requirements (clearly state the service denied and the reason). United must remove any reference to an ABN. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5532	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued in a timely manner per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5532	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is completed per CMS requirements when issued. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0151	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0316	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H0316	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0316	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0316	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0316	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H0316	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0316	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H0316	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0401	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H0401	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0401	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0401	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0401	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H0401	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0401	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0401	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0624	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H0624	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0624	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0624	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0624	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H0624	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0624	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H0624	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-202-383-6402	H1080	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1111	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1111	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1111	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H1111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H1111	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2654	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2802	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H2802	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2802	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2802	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2802	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2802	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2802	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2802	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2803	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2803	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2803	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2803	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2803	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H2803	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2803	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H2803	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3379	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3379	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3379	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3379	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3379	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H3379	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3379	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3379	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3456	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H3659	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4102	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H4102	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4102	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4102	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4102	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4102	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4102	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4102	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4106	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
UnitedHealth Group, Inc.	1-952-931-5336	H4106	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4106	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4106	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4106	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4106	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4106	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4106	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4406	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4406	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4406	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4406	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4514	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4514	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4514	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4514	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4514	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4514	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4514	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4514	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4604	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4604	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4604	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4604	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4604	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H4604	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4604	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H4604	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5008	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5008	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5008	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5008	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5008	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5008	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5008	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered; · Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · Offer gifts or payment as an inducement to enroll in the organization; ·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.	Although United does have an excellent web-based training for the sales force that includes testing modules, there needs to be a more thorough tracking system developed and implemented on what training is available, when the sales force is required to take the training, what scores are achieved on the testing modules and internal controls to better monitor the overall training of the sales force. United must implement a mechanism to track licensure. United must revise internal policies and procedures that address marketing representatives files to ensure that documentation is maintained. United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve the oversight control of the sales force to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance with CMS requirements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	United must provide documentation to CMS that ensures that Pre-service denials are issued in a timely manner. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5253	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5440	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5440	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5440	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5440	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H5440	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H5440	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H9011	MA	Audit Findings	12/15/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	United must design and implement a comprehensive process improvement to assure 2008 ANOCs are not late.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H9011	MA	Audit Findings	12/15/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	United must revise and provide to CMS internal policies and procedures to ensure that credentialing files meet CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H9011	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	United must improve oversight controls for delegated entities to ensure compliance with CMS requirements. United must submit a strategy to CMS detailing the specific improvements that will be utilized to ensure compliance.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H9011	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	United must provide documentation to CMS that ensures that EOBs with appeal rights are correctly generated for all denied services. In addition, because the Medicare Advantage program has not implemented any requirements for ABNs, United must remove all language referring to ABNs from its EOBs. United must implement oversight controls to ensure CMS compliance. United must provide to CMS a strategy which describes the type of oversight activities it will implement in order to maintain compliance.	Closed

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UnitedHealth Group, Inc.	1-952-931-5336	H9011	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	United must revise and provide to CMS internal policies and procedures to ensure that members are notified both orally and in writing per CMS requirements. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements.	Closed
UnitedHealth Group, Inc.	1-952-931-5336	H9011	MA	Audit Findings	12/15/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	United must revise and provide to CMS internal policies and procedures to ensure that the detailed notice of explanation is issued timely. In addition, United must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training and individuals being trained. United must improve oversight controls to ensure CMS compliance. United should submit a strategy to CMS detailing the specific improvements	Closed
Humana Inc.	1-502-580-3683	H1951	MA	Audit Findings	12/5/2006	Closed	Chapter 11 - Contracts	Required Contract Provision: Prompt PaymentThe MAO's written contracts with first tier and downstream entities must contain a prompt payment provision.	CMS requests a Corrective Action Plan for H1951 indicating planned action to be taken to assure contract signature pages are dated as required in Contract worksheet instructions which indicate, "Contracts must be signed and Dated by both parties to be considered a valid Contract."	Closed
Humana Inc.	1-502-580-3683	H1951	MA	Audit Findings	12/5/2006	Closed	Chapter 11 - Contracts	Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.	CMS requests a Corrective Action Plan for H1951 indicating planned action to be taken to assure contract signature pages are dated as required in Contract worksheet instructions which indicate, "Contracts must be signed and Dated by both parties to be considered a valid Contract."	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Humana Inc.	1-502-580-3683	H1951	MA	Audit Findings	12/5/2006	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	CMS requests a Corrective Action Plan for H1951 indicating planned action to be taken to assure contract signature pages are dated as required in Contract worksheet instructions which indicate, "Contracts must be signed and Dated by both parties to be considered a valid Contract."	Closed
Humana Inc.	1-502-580-3683	H1951	MA	Audit Findings	12/5/2006	Closed	Chapter 11 - Contracts	Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe MAO's written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO's policies and procedures.	CMS requests a Corrective Action Plan for H1951 indicating planned action to be taken to assure contract signature pages are dated as required in Contract worksheet instructions which indicate, "Contracts must be signed and Dated by both parties to be considered a valid Contract."	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	AMH is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, AMH will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe to CMS no later than July 15, 2007 for sample selection.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	AMH is required to submit a new universe for sample selection and CMS Desk Review. CMS reviewers noted that of the 15 cases provided 10 did not have a resolution included in the case file. CMS reviewer also noted that the Polices and Procedures were not followed as it relates to the grievance cases. AMH must revise its policies and procedures and conduct training of appropriate staff to ensure that procedures are followed. AMH must submit documentation to the regional office that details the nature of this training. Please make sure that the documentation include, the materials used in the training, the individuals conducting the training, and the individuals being trained. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe to CMS no later than July 15, 2007 for sample selection.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	AMH is required to submit a new universe for sample selection and CMS Desk Review. CMS reviewers noted that of the 15 cases provided 10 did not have a resolution included in the case file. CMS reviewer also noted that the Polices and Procedures were not followed as it relates to the grievance cases. AMH must revise its policies and procedures and conduct training of appropriate staff to ensure that procedures are followed. AMH must submit documentation to the regional office that details the nature of this training. Please make sure that the documentation include, the materials used in the training, the individuals conducting the training, and the individuals being trained. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe to CMS no later than July 15, 2007 for sample selection.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	AMH is required to submit a new universe for sample selection and CMS Desk Review. CMS reviewers noted that of the 15 cases provided 10 did not have a resolution included in the case file. CMS reviewer also noted that the Polices and Procedures were not followed as it relates to the grievance cases. AMH must revise its policies and procedures and conduct training of appropriate staff to ensure that procedures are followed. AMH must submit documentation to the regional office that details the nature of this training. Please make sure that the documentation include, the materials used in the training, the individuals conducting the training, and the individuals being trained. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe to CMS no later than July 15, 2007 for sample selection.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	AMH is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, AMH will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. AMH should review the universe description to ensure that that the proper cases are selected. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe to CMS no later than July 15, 2007 for sample selection.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	AHM must forward its newly developed Policies and Procedures that outlines the timely payment of clean claims, as well as the process used for identifying late claims and payment of interest on those claims. AHM must also provide a timeline of their process to rectify the issue and improve the system automatic denial of claims.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	AMH is required to submit to CMS a new universe in order for the new cases to be selected for review. Once cases are selected by CMS, AMH will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed

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American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	AMH is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, AMH will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.	AMH is required to submit systematic instructions to identify Medicare Secondary Payers. These Policy and Procedures should include timeframes, complete process description, responsibilities of staff involved and any sample letters that will be utilized.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	AMH is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these case are selected by CMS, AMH will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	AMH is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, AMH will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. AMH should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	AHM needs to make the following updates to Policy and Procedure- AHMMM024:- In this P and P, consider bolding the beginning paragragh or using a Header to distinguish between the different sections for Receipt and Documentatiion, Expedited Request, and denial etc. As referenced on Page #5, include a copy of the written letter with Policy and Procedure. AS referenced on Page #6, attach "The Notice of Denial of Medical Coverage" to the Policy and Procedure. As referenced on Page #7, provide a copy of the standard notices.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	AMH is required to submit a new universe for WS-OP1 and CMS will select cases for a desk audit. AMH must ensure the letters submitted with the case documentation include the appropriate language. AMH must include with Policy and Procedure MM 005 a copy of the letter provided to member when an organization determination extension is utilized.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	AMH is required to submit a new universe for WS-OP1 and CMS will select cases for a desk audit. Once these cases are reviewed the results will be combined with WS-OP2 to make a determination on this element.	Closed

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American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	AHM must provide Policy and Procedure AHMMM028 with the Detailed Explanation of Non- Coverage and other attachments stated in No.# 7 on Page 3.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Notice of Non-Coverage of Inpatient Hospital Care - The MAO must provide notice to the enrollee of its decision (or that of the delegated provider) of non-coverage of further hospital care no later than the day before hospital coverage ends when the enrollee disagrees with the discharge or noncoverage decision. Prior to issuance of this notice, the MAO secures concurrence from the physician responsible for the patient's care in the hospital. The MAO's notice of non-coverage of further inpatient hospital care must include the reason why further inpatient hospital care is no longer needed; the date and time of the enrollee's liability for continued impatient care; and the enrollee's appeal rights.	AHM must provide to CMS a written Policy and Procedure which outlines Non- Coverage for Inpatient Hospital Care. The Policy and Procedure must include the attachment OMB Approval No. 0938-0692. Form No. CMS-R-193.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	AMH must submit Policy and Procedures regarding the adverse claims reconsideration when AMH upholds its initial determination. This policy and procedure must include what happens when the case is sent to the Independent Review Entity and member notification.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	AMH must revise this policy to include information regarding effectuation decision of ALJ or higher levels of appeals.	Closed

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American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Acceptance of Standard Reconsideration Requests - The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).	AHM must provide a written policy and procedurewhich address standard reconsideratio Request and the following below :- Information on accepting written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination. See 70.2 Information that includes "if good cause is shown,AHM will accept written requests for standard reconsideration after 60 calendar days". See 70.3. On page #2, reference to forwarding "an event " to Quality Department by the RN reviewer if no response from the member after three calls and one letter. AHM must include that if there is no signed acknowledgement by the member by the conclusion of the appeal timeframe, plus extension that the case should be referred to the independent review entity with a request for denial. See 70.2	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Appropriate Person(s) Conduct the Reconsideration A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is a denial based on lack of medical necessity, the reconsidered determination must be made by a physician with the expertise in the field of medicine that is appropriate for the service at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.	AHM must provide a policy and procedure which addresses the process for Standard Reconsideration Request. This policy must also include information on the appropriate person (s) conducting the Reconsiderations.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).	AHM must provide a "Policy and Procedure" which outlines all the processes for "Favorable Standard pre-Service Reconsideration". Please see Chapter 13: 70.7.1 of the "Medicare Managed Care Manual".	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.	AHM must provide a "Policy and Procedure" which outlines all the processes for "Adverse Standard Pre-Service Reconsiderations". Please see Chapter 13: 70.7.3 of the "Medicare Managed Care Manual".	Closed

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American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	AHM must include information in the "Policy and Procedure" - AHMAG007 which addresses information pertaining to the "MAO's determination being reversed in whole or in part by an ALJ, or at a higher level of appeal was not included in policy and procedure AHMAG007. Information on AHM authorizing or providing the service under dispute as expeditiously as the member's health requires no later than 60 days from the date it received notice of the reversal" is missing. See Chapter 13: 140.3 of the "Medicare Managed Care Manual".	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Reconsideration Requests - The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.	AHM's "Policy and Procedure" - AHMAG006 must include information which address the process for submitting "Expedited Reconsiderations" when it is oral versus written, and should also include information and the process for maintaining a case file on documented oral requests.	Closed

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American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.	AHM must included in its Policy and Procedure: The "Denial Request for Expedited Appeal Letter referred to on Page 2 of the "Policy and Procedure" was not attached. Information was not included in the "Policy and Procedure" process on "if AHM makes an expedited reconsideration that is favourable to the member. Although AHM included the 72 hours timeframe for notification on an oral requests, information was not provided concerning "sending a written notice within 3 calendar days of the oral notice". See Chapter 13 - 80.1 of the "Medicare Managed Care Manual". AHM please explain the following below: Information provide on page #2 of this policy and procedure on the MD Reviewer,please clarify how this section ties in with the expedited appeal process?	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	AHM Policy and Procedure,AHMAG006 must contain the following: Contents on MAO time frame for processing "Decisions not to Expedite Reconsiderations". Instructions on how the member will be provided with information about their rights to file a grievance. Information on how to resubmit a request for an expedited reconsideration with a physician's support. Instructions on AHM grievance process and timeframe. Please refer to Chapter 13 - 80.1 of the Medicare Managed Care Manual.	Closed

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American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.	AHM must include the following information in its "Policy and Procedure" - AHMAG007: Information and AHM process for addressing if its determination if reversed in whole or in part by an ALJ, or a higher level of appeal. Information and process on how AHM authorize or provide the service under dispute as expeditiously as the member's health requires, no later than 60 days from the date of the received notice of the reversal.	Closed
American Health Plan	1-787-620-1919 Ext. 4014	H5774	MA	Audit Findings	11/7/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	AHM must include in its "Policies and Procedures"- AHMMM028 and AHMMM025 The written notice to the member. The Policy and Procedure must include the process for an extension if it is required.	Closed
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 05 - Quality Assurance	Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).	Submit to the Regional Office a description of a chronic care improvement program.	Closed
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.	Universal Care, Inc. must be able to document that their provider contracts have been appropriately amended to include the new MMA language "agree to audits and inspection by CMS and/or its designees, cooperate, assist, and provide information, as requested, and maintain records a minimum of 10 years." Submit to the Regional Office a corrective action plan to appropriately amend the provider contracts and to document the sending / receipt of the amendment. Provide a timeline for completion of the amending of the provider contracts.	Closed
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	Universal Care has submitted a revised notice that includes required language describing a member's right to file a written complaint with the QIO for quality of care issues. The notice has been approved. No further action is necessary.	Closed
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	Describe the specific actions that Universal Care is taking to ensure that it issues denial notices to members whenever it denies payment of services to a non-contracted provider and the time-frames for these actions. Denial reasons related to the majority of the cases in this sample may explain that the services in question are not covered by Medicare and therefore not payable or that Universal Care requested additional information to determine whether payment of the claim was appropriate but never received the information. Universal Care may also want to include in the denial language instructions for members to contact the plan should they receive a bill from providers for the denied services for these reasons.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).	Submit a corrective action plan, describing the actions Universal Care, Inc. will take to meet the 14 calendar day time frame for processing standard pre-service organization determinations.	Closed
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	Submit a corrective action plan, describing the actions Universal Care, Inc. will take to assure that it uses the CMS approved NDMC. Provide a timeline when the CMS approved NDMC will be fully adopted.	Closed
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Universal Care must analyze its process to determine what caused the payment delay once it made the reconsideration decision and describe steps it is taking to ensure that it pays claim reconsideration reversals within the regulatory time frame. As part of the CAP, Universal Care must provide CMS with quarterly reports on its performance beginning with the first quarter of 2007.	Closed
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	Universal Care must develop and submit for CMS approval a notice advising members that it has decided not to expedite review of their reconsideration request and that it will process the reconsideration under standard reconsideration timeframes. The notice must also include language advising members of the right to file an expedited grievance if they disagree or to resubmit the request with a support from a physician.	Closed
Universal Care, Inc	1-562-981-5054	H0838	MA	Audit Findings	10/30/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	Universal Care must develop and submit for CMS approval a notice advising members that it has decided to take an extension on their reconsideration. The notice must explain the plan's reason(s) for the delay and advise members of the right to file an expedited grievance if they disagree.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from February 2007 to July 2007. COSVI should submit the Universe sample to CMS no later than August 15, 2007 for case selection.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. COSVI must make sure that the documentation submitted includes the letter sent to the member about the resolution of the grievance. CMS has determined the time period will be from February 2007 to July 2007. COSVI should submit the Universe sample to CMS no later than August 15, 2007 for case selection.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from February 2007 to July 2007. COSVI should submit the Universe sample to CMS no later than August 15, 2007 for case selection.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.	COSVI must revise its policies and procedures to ensure correct processing of claims and the development of claims for additional information. COSVI must conduct training of appropriate staff on these policies and procedures and submit documentation to the Regional Office that details the nature of this training, including: the materials used in the training, the individuals conducting training and the individuals being trained.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	COSVI must ensure that all non-contracted claims that do not meet the definition of "clean claims" are paid within 60 calendar days of receipt. MAO must submit monthly report from February 2007 to July 2007 showing non-contracted non-claims that were paid within 60 calendar days of receipt.	Closed

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Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	MAO must issue an OMB approved Notice of Denial Payment (CMS-10003-Notice of Denial of Payment (NDP)) to the beneficiary within 60 days of the request for payment. The Notice must provide the beneficiary with the name of the provider, date and type of service and basis for denial. COSVI must ensure that its claims department follows these instructions and that they are reflected in its policy and procedures manual.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. COSVI should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. COSVI should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	COSVI is required to submit a new universe for WS-OP2 and CMS will select cases for a desk audit. COSVI must ensure the letters submitted with the case documentation include the appropriate language. COSVI must include with Policy and Procedure #701-05 a copy of the letter provided to member when an organization determination extension is utilized.	Closed

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Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	COSVI is required to submit a new universe for WS-OP2 and CMS will select cases for a desk audit. COSVI must ensure the letters submitted with the case documentation include the appropriate language. COSVI must include with Policy and Procedure #702-05 a copy of the letter provided to members when there is a decision not to expediate an organization determination.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. COSVI should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	COSVI must submit for CMS review policy and procedure that address Termination of provider services for SNF, HHA OR CORF. This policy and procedure must include the CMS required timframes.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	COSVI must submit a copy of a detailed explanation of non coverage of provider services for CMS review.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. COSVI should submit the Universe sample to CMS no later than July 15, 2007 for case selection	Closed

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Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. COSVI should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	COSVI is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, COSVI will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from January 2007 to June 2007. COSVI should submit the Universe sample to CMS no later than July 15, 2007 for case selection.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	COSVI must include with Policy and Procedure #702-05 a copy of the letter provided to members when there is a decision not to expedite an organization determination.	Closed
Cooperativa de Seguros de Vida de Puerto Rico	1-787-751-5656 Ext. 2425	H5760	MA	Audit Findings	10/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	COSVI must include with Policy and Procedure #702-05 a copy of the letter provided to member when a Reconsideration extension is utilized.	Closed

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First Medical Health Plan	1-787-625-9557 Ext. 323	H4011	MA	Ad-Hoc Compliance Event	9/9/2006	Closed	Chapter 03 - Marketing	No Engagement in Activities which Mislead, Confuse or Misrepresent MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO and: · May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; · May not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · May not accept plan applications in provider offices or other places where health care is delivered; · May not employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); · May not offer gifts or payment as an inducement to enroll in the organization; · May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and · May not conduct door-to-door solicitation of Medicare beneficiaries.	First Plus submitted during the CMS's audit of August 2, 2006 the following Corrective Action Plan: OCCURRENCE REPORT CORRECTIVE ACTION PLAN Type of Incident:Regional Sales Supervisors Failure to Report Marketing Incidents and Grievances to Compliance Officer First+Plus Parties Involved:Sales & Marketing Department Government Affairs Department Non-First+Plus Parties Involved:Members First+Plus Plans Involved:All Date of Occurrence:August 1, 2006 Date Compliance Notified:August 1, 2006 Date Investigation Completed: August 2, 2006 Person Completing Investigation:Carlos Fournier Gustavo Pérez Summary: While reviewing Sales Representative files during the CMS audit, it was noted that Regional Sales Supervisors had been documenting marketing incidents and member grievances in memorandums to Sales Representatives, however, the Compliance Officer and Grievances and Appeals Coordinator was not notified of the occurrences. CMS regulations require that Medicare Advantage organizations monitor and log all grievances and appeals as well as monitor sales activities. It was noted that the dates of the occurrences were prior to the Grievances and Appeals training that was conducted on May 26, 2006 by the Compliance Officer. Corrective Action Plan: ¿The Compliance Officer will send a memorandum to the Sales & Marketing Manager and all Regional Sales Supervisors reminding them of the Grievances and Appeals training and requirement that the Compliance Officer be notified of all oral or written grievances and appeals for monitoring and tracking purposes. ¿The Regional Sales Managers will be notified that the Compliance Officer and Sales Manager are to receive copies of all memorandums or correspondence regarding Marketing Incidents. ¿The Regional Sales Managers are being requested to provide the Compliance Officer with all copy of all memorandums issued to date regarding any marketing incidents, grievances or appeals within thirty days. ¿The Sales & Marketing Manager will review all future memorandums regarding marketing incidents to ensure that it documents a copy was submitted to the Compliance Officer. ¿The Compliance Officer will conduct a follow-up audit of at least 20 sales representative files within four months to ensure that Government Affairs was notified of all marketing incidents, grievances or appeals. Conclusion: First+Plus failed to track all grievances regarding Sales and Marketing matters. A Grievances and Appeals training session was provided to all First+Plus Regional Sales Managers on May 26, 2006. The Compliance Officer is requesting copies of all prior incidents so that the grievances log can be updated and additional investigation conducted, if needed. The Sales Representative files will be audited within four months to ensure compliance or identify outliers or if additional training needs to be conducted. Based on our review of First Plus' CAP, further actions are required. They are the following: - First Plus must provide evidence that the two marketing incidents found in the sales representatives file's were investigated and the resolution reached. This information must	Closed

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									be documented in the sales representative's files. -First Plus must conduct periodic audits on sales representative's files to ensure that any marketing incident is investigated according to CMS marketing guidelines. -A monthly report on these audits should be submitted to CMS beginning in September of 2006 and ending in December of 2006. In addition, First Plus must provide proof to demonstrate that all departments involved in customer relations/service are cross-trained and have a clear understanding of what a marketing incident/violation is and grievances and appeals via training. Policies and procedures must be revised to include the CAP items listed in First Plus' CAP. The CAP for this element will be closed when all requirements have been met.	
First Medical Health Plan	1-787-625-9557 Ext. 323	H4011	MA	Ad-Hoc Compliance Event	9/9/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Adjudication - The MAO must adjudicate internal grievances in a manner fully consistent with the MAO's written grievance procedure, as stated in the EOC.	- First Plus Compliance Department must immediately investigate all identified "marketing incidents" from the sample. - First Plus must prepare a report with its findings and corrective action taken. The report must be submitted to the CMS Regional Office with its Corrective Action Plan. -First Plus must ensure that it follows its Grievance Process as it is explained in its Policies and Procedures and Evidence of Coverage. All Marketing Incidents received either by phone or in writing must be referred to the Sales Department for investigation. Results of its investigations must be included in the grievance file.	Closed
First Medical Health Plan	1-787-625-9557 Ext. 323	H4011	MA	Ad-Hoc Compliance Event	9/9/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	While the CMS team was onsite, First Plus submitted a Corrective Action Plan (CAP) detailing the steps that it will take to cure the deficiencies. The CMS Reviewer reviewed the CAP while on site and accepted it as submitted. Type of Incident: Claims-OC2 denied claims universe provided incorrect date. (THIS WORKSHEET MEASURES ELEMENT OC01) Summary: During the CMS audit, it was determined that the OC2 Denied Claims sample included an incorrect date. The date provided should have been the adjudication date but instead reflected the Explanation of Payment date. Corrective Action Plan: In the future, the denied date will be defined as the adjudication date of the claim. Further Comment/Suggestions: Re-write report with the correct date and will be reflected on any future reports. Further Action Required: In regard to the incorrectly denied claims (denied for pre-authorization)- included in Worksheet OC01- First Plus must provide a Corrective Action plan detailing the actions taken to correct this error. For example: How many claims were affected? Was there a systems error? Was there a keying error? The plan made reference to this discovery during the review and did not provide a CAP for the claims affected.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
First Medical Health Plan	1-787-625-9557 Ext. 323	H4011	MA	Ad-Hoc Compliance Event	9/9/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	CMS reviewed First Plus's CAP provided on site detailing the steps that it will take to cure the identified deficiencies. CMS reviewed the CAP and partially accepts it as submitted. The actions that First Plus states it will implement to cure the identified deficiencies address only how it will pay the interest on claims over 30 days. However, the CAP must also include what measures the plan will take to avoid claims being delayed beyond the required 30 days. The submitted CAP follows: OCCURRENCE REPORT CORRECTIVE ACTION PLAN Type of Incident:Claims Payment Failure to Pay Interest First+Plus Parties Involved: Claims Department Accounting Department Information Systems Department Non-First+Plus Parties Involved: Providers / Members First+Plus Plans Involved:All Date of Occurrence:May 2006 Date Compliance Notified:May 2006 Date Investigation Completed:June 30, 2006 Person Completing Investigation:Carlos Fournier Kristin Greeley and Luis Estrada Summary: While conducting an internal self audit, Claims determined that interest had not been calculated or paid on claims paid greater than 30 days for non-participating providers and greater than 45 days for member reimbursements and participating providers. Puerto Rico state regulations require that members and participating providers are paid interest on claims payments made greater than 45 days at the state interest rate and non-participating providers are paid interest on claims payments made greater than 30 days at the federal interest rate. Corrective Action Plan: Information Systems created a one-time program to analyze past claims payments and calculate interest that should have been paid. On June 2, 2006 First+Plus processed a batch of checks for all prior paid claims where interest should have been paid and was not paid. The Claims and Accounting Payment System was updated to ensure future claims payments include interest if applicable. Claims Manager will continue to monitor interest payment calculations during the check processing cycles. Conclusion: First+Plus failed to pay interest on claims and was in violation of CMS and state regulations. The deficiency was rectified by making interest payments on previously processed claims. The Claims Processing system was updated to ensure future interest payments are processed with the weekly check process.	Closed

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									Further Comment/Suggestions: Claims Manager will perform an audit in 30 days to ensure that interest is being paid and that the interest calculations are correct. End of Plan CAP---- Further action required by CMS: First Plus must establish systems flags to alert the plan when claims are approaching the 30 days benchmark. First Plus must conduct weekly audits to ensure that claims are being paid on time and interest paid where applicable. First Plus must submit a monthly report to the Regional Office starting with the month of October (for the month of September 06) showing the claims received, processing time and interest paid.	
First Medical Health Plan	1-787-625-9557 Ext. 323	H4011	MA	Ad-Hoc Compliance Event	9/9/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	First Plus must ensure that it makes a determination on a denied claim within the required 60 days. First Plus must submit a monthly report that will include date of receipt, and date of denial determination. The first report must be submitted in October for the month of September 06.	Closed
First Medical Health Plan	1-787-625-9557 Ext. 323	H4011	MA	Ad-Hoc Compliance Event	9/9/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Receipt and Documentation of Expedited Organization Determination Requests - The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.	Required corrective actions: Refresher training on full expedited organization determination requests process (including accepting verbal and written requests from all acceptable individuals). Revised policies and procedures for all departments that include acceptance from acceptable individuals: member, court-appointed representative, physician, etc). Actions taken: Departmental staff were instructed as to the full process; accepting expedited organization determination requests from all acceptable individuals (not just physicians)during the onsite. In addition, they were instructed as to what to do with verbal requests received by Customer Service, Grievance and Appeals and UM departments). Internal policies and procedures for all departments involved were revised while CMS staff was onsite. They were reviewed and accepted as written. Therefore, no further action is required in this element.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
First Medical Health Plan	1-787-625-9557 Ext. 323	H4011	MA	Ad-Hoc Compliance Event	9/9/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	First Plus must accept verbal requests (received at Customer Service) nd must continue to ensure that it promptly decides whether to expedite an organization determination based on regulatory requirements. If it decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of reeipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If First Plus makes an expedited organization determination,(favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If First Plus first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification. See 42 CFR 422.(c)(2) and (d); 422.572(a)-(c). First Plus staff must be careful in entering case information into the PLEXIS system. Because First Plus provided all required revisions to Policies and Procedures for UM, and Customer Service Departments while the team was onsite, no further documentation will be required.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	The MAO must follow CMS' marketing guidelines when submitting materials.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO must establish and maintain a system for confirming that enrolled members are enrolled in the MA plan and that they understand the rules applicable under the plan.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Materials Provided For Significant Non-English Speaking Population - For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.	The MAO must develop materials for the significant Non-English speaking population in the Texas market.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	The MAO must establish policies and procedures to review the Medicare Opt Out list during the initial and recredentialing process. In addition, the MAO must conduct a self-audit monthly of at least five initial and/or recredentialing files, including completing the WS-PR1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	The MAO must process grievances within the required timeframe. In addition, the MAO must conduct a self-audit monthly of at least five Grievances, including completing the WS-GV1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	The MAO must properly address all issues raised in the grievance. In addition, the MAO must conduct a self-audit monthly of at least five Grievances, including completing the WS-GV1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	The MAO must make timely and reasonable payment to, or on behalf of the plan enrollee from a provider or supplier that does not contract with the MAO to provide services covered by the MA plan.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	The MAO's delegated entity must timely pay Non-Contracted provider clean claims within thirty days. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted Provider Paid Claims processed by your delegated entity, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must pay the correct interest amount on all clean claims processed over thirty days. In addition, the MAO must conduct a self-audit monthly of at least five clean claims from Non-contracted provider, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

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Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The MAO must adjudicate non-clean claims from Non-Contracted providers within sixty days. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted provider paid claims, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must use the CMS approved denial notice. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted denied provider claims, including completing the WS-OC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MAO must process requests for Expedited Organization Determinations timely. In addition, the MAO must conduct a self-audit monthly of at least five Requests for Expedited Organization Determinations, including completing the WS-OP2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	The MAO must develop a written notice template for Organization Determination Extensions.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	The MAO must develop a notice for cases in which the decision was not to expedite the Organization Determination.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	The MAO must send the Detailed Explanation of Non-Coverage of Provider Services timely. In addition, the MAO must conduct a self-audit monthly of at least five QIO Review of Termination of Services, including completing the WS-OP5 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	The MAO must use the correct Detailed Explanation of Non-Coverage of Provider Services (CMS-10095-B). In addition, the MAO must conduct a self-audit monthly of at least five QIO Review of Termination of Services, including completing the WS-OP5 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MAO must process Favorable Claims Reconsiderations in a timely manner. In addition, the MAO must conduct a self-audit monthly of at least five Favorable Claims Reconsiderations, including completing the WS-RC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	The MAO must process Adverse Claims Reconsiderations timely. In addition, the MAO must conduct a self-audit monthly of at least five Unfavorable Claims Reconsiderations, including completing the WS-RC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	The MAO must effectuate Third-Party Claims Reconsideration Reversals timely. In addition, the MAO must conduct a self-audit monthly of at least five Unfavorable Claims Reconsiderations, including completing the WS-RC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

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Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	The MAO must develop a written notice template for Decisions Not to Expedite a Reconsideration.	Closed
Bravo Health, Inc.	1-410-864-4437	H2108	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	The MAO must develop a written notice template for Reconsideration Extensions.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	The MAO must follow CMS' marketing guidelines when submitting materials.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO must establish and maintain a system for confirming that enrolled members are enrolled in the MA plan and that they understand the rules applicable under the plan.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Materials Provided For Significant Non-English Speaking Population - For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.	The MAO must develop materials for the significant Non-English speaking population in the Texas market.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	The MAO must establish policies and procedures to review the Medicare Opt Out list during the initial and recredentialing process. In addition, the MAO must conduct a self-audit monthly of at least five initial and/or recredentialing files, including completing the WS-PR1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	The MAO must process grievances within the required timeframe. In addition, the MAO must conduct a self-audit monthly of at least five Grievances, including completing the WS-GV1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	The MAO must properly address all issues raised in the grievance. In addition, the MAO must conduct a self-audit monthly of at least five Grievances, including completing the WS-GV1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	The MAO must make timely and reasonable payment to, or on behalf of the plan enrollee from a provider or supplier that does not contract with the MAO to provide services covered by the MA plan.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	The MAO's delegated entity must timely pay Non-Contracted provider clean claims within thirty days. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted Provider Paid Claims processed by your delegated entity, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must pay the correct interest amount on all clean claims processed over thirty days. In addition, the MAO must conduct a self-audit monthly of at least five clean claims from Non-contracted provider, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The MAO must adjudicate non-clean claims from Non-Contracted providers within sixty days. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted provider paid claims, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must use the CMS approved denial notice. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted denied provider claims, including completing the WS-OC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MAO must process requests for Expedited Organization Determinations timely. In addition, the MAO must conduct a self-audit monthly of at least five Requests for Expedited Organization Determinations, including completing the WS-OP2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	The MAO must develop a written notice template for Organization Determination Extensions.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	The MAO must develop a notice for cases in which the decision was not to expedite the Organization Determination.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	The MAO must send the Detailed Explanation of Non-Coverage of Provider Services timely. In addition, the MAO must conduct a self-audit monthly of at least five QIO Review of Termination of Services, including completing the WS-OP5 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	The MAO must use the correct Detailed Explanation of Non-Coverage of Provider Services (CMS-10095-B). In addition, the MAO must conduct a self-audit monthly of at least five QIO Review of Termination of Services, including completing the WS-OP5 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MAO must process Favorable Claims Reconsiderations in a timely manner. In addition, the MAO must conduct a self-audit monthly of at least five Favorable Claims Reconsiderations, including completing the WS-RC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	The MAO must process Adverse Claims Reconsiderations timely. In addition, the MAO must conduct a self-audit monthly of at least five Unfavorable Claims Reconsiderations, including completing the WS-RC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	The MAO must effectuate Third-Party Claims Reconsideration Reversals timely. In addition, the MAO must conduct a self-audit monthly of at least five Unfavorable Claims Reconsiderations, including completing the WS-RC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

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Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	The MAO must develop a written notice template for Decisions Not to Expedite a Reconsideration.	Closed
Bravo Health, Inc.	1-410-864-4437	H3949	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	The MAO must develop a written notice template for Reconsideration Extensions.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	The MAO must follow CMS' marketing guidelines when submitting materials.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO must establish and maintain a system for confirming that enrolled members are enrolled in the MA plan and that they understand the rules applicable under the plan.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Materials Provided For Significant Non-English Speaking Population - For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.	The MAO must develop materials for the significant Non-English speaking population in the Texas market.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	The MAO must establish policies and procedures to review the Medicare Opt Out list during the initial and recredentialing process. In addition, the MAO must conduct a self-audit monthly of at least five initial and/or recredentialing files, including completing the WS-PR1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

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Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	The MAO must process grievances within the required timeframe. In addition, the MAO must conduct a self-audit monthly of at least five Grievances, including completing the WS-GV1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	The MAO must properly address all issues raised in the grievance. In addition, the MAO must conduct a self-audit monthly of at least five Grievances, including completing the WS-GV1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	The MAO must make timely and reasonable payment to, or on behalf of the plan enrollee from a provider or supplier that does not contract with the MAO to provide services covered by the MA plan.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	The MAO's delegated entity must timely pay Non-Contracted provider clean claims within thirty days. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted Provider Paid Claims processed by your delegated entity, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must pay the correct interest amount on all clean claims processed over thirty days. In addition, the MAO must conduct a self-audit monthly of at least five clean claims from Non-contracted provider, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

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Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The MAO must adjudicate non-clean claims from Non-Contracted providers within sixty days. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted provider paid claims, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must use the CMS approved denial notice. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted denied provider claims, including completing the WS-OC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MAO must process requests for Expedited Organization Determinations timely. In addition, the MAO must conduct a self-audit monthly of at least five Requests for Expedited Organization Determinations, including completing the WS-OP2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	The MAO must develop a written notice template for Organization Determination Extensions.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	The MAO must develop a notice for cases in which the decision was not to expedite the Organization Determination.	Closed

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Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	The MAO must send the Detailed Explanation of Non-Coverage of Provider Services timely. In addition, the MAO must conduct a self-audit monthly of at least five QIO Review of Termination of Services, including completing the WS-OP5 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	The MAO must use the correct Detailed Explanation of Non-Coverage of Provider Services (CMS-10095-B). In addition, the MAO must conduct a self-audit monthly of at least five QIO Review of Termination of Services, including completing the WS-OP5 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MAO must process Favorable Claims Reconsiderations in a timely manner. In addition, the MAO must conduct a self-audit monthly of at least five Favorable Claims Reconsiderations, including completing the WS-RC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	The MAO must process Adverse Claims Reconsiderations timely. In addition, the MAO must conduct a self-audit monthly of at least five Unfavorable Claims Reconsiderations, including completing the WS-RC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	The MAO must effectuate Third-Party Claims Reconsideration Reversals timely. In addition, the MAO must conduct a self-audit monthly of at least five Unfavorable Claims Reconsiderations, including completing the WS-RC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

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Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	The MAO must develop a written notice template for Decisions Not to Expedite a Reconsideration.	Closed
Bravo Health, Inc.		H3972 (Novation)	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	The MAO must develop a written notice template for Reconsideration Extensions.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.	The MAO must follow CMS' marketing guidelines when submitting materials.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.	The MAO must establish and maintain a system for confirming that enrolled members are enrolled in the MA plan and that they understand the rules applicable under the plan.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 03 - Marketing	Materials Provided For Significant Non-English Speaking Population - For markets with a significant non-English speaking population, the MAO provides materials in the language of these individuals.	The MAO must develop materials for the significant Non-English speaking population in the Texas market.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 06 - Provider Relations	Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.	The MAO must establish policies and procedures to review the Medicare Opt Out list during the initial and recredentialing process. In addition, the MAO must conduct a self-audit monthly of at least five initial and/or recredentialing files, including completing the WS-PR1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.	The MAO must process grievances within the required timeframe. In addition, the MAO must conduct a self-audit monthly of at least five Grievances, including completing the WS-GV1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.	The MAO must properly address all issues raised in the grievance. In addition, the MAO must conduct a self-audit monthly of at least five Grievances, including completing the WS-GV1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.	The MAO must make timely and reasonable payment to, or on behalf of the plan enrollee from a provider or supplier that does not contract with the MAO to provide services covered by the MA plan.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	The MAO's delegated entity must timely pay Non-Contracted provider clean claims within thirty days. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted Provider Paid Claims processed by your delegated entity, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).	The MAO must pay the correct interest amount on all clean claims processed over thirty days. In addition, the MAO must conduct a self-audit monthly of at least five clean claims from Non-contracted provider, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

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Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.	The MAO must adjudicate non-clean claims from Non-Contracted providers within sixty days. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted provider paid claims, including completing the WS-OC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must use the CMS approved denial notice. In addition, the MAO must conduct a self-audit monthly of at least five Non-contracted denied provider claims, including completing the WS-OC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.	The MAO must process requests for Expedited Organization Determinations timely. In addition, the MAO must conduct a self-audit monthly of at least five Requests for Expedited Organization Determinations, including completing the WS-OP2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.	The MAO must develop a written notice template for Organization Determination Extensions.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited determination with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	The MAO must develop a notice for cases in which the decision was not to expedite the Organization Determination.	Closed

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Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.	The MAO must send the Detailed Explanation of Non-Coverage of Provider Services timely. In addition, the MAO must conduct a self-audit monthly of at least five QIO Review of Termination of Services, including completing the WS-OP5 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.	The MAO must use the correct Detailed Explanation of Non-Coverage of Provider Services (CMS-10095-B). In addition, the MAO must conduct a self-audit monthly of at least five QIO Review of Termination of Services, including completing the WS-OP5 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	The MAO must process Favorable Claims Reconsiderations in a timely manner. In addition, the MAO must conduct a self-audit monthly of at least five Favorable Claims Reconsiderations, including completing the WS-RC1 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.	The MAO must process Adverse Claims Reconsiderations timely. In addition, the MAO must conduct a self-audit monthly of at least five Unfavorable Claims Reconsiderations, including completing the WS-RC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.	The MAO must effectuate Third-Party Claims Reconsideration Reversals timely. In addition, the MAO must conduct a self-audit monthly of at least five Unfavorable Claims Reconsiderations, including completing the WS-RC2 worksheet until you come into compliance with CMS' requirements. The report of findings must be submitted to CMS by the 15th of each month. The first report will be due October 15, 2006 for the self-audit conducted in the month of September 2006.	Closed

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Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.	The MAO must develop a written notice template for Decisions Not to Expedite a Reconsideration.	Closed
Bravo Health, Inc.	1-410-864-4437	H4528	MA	Audit Findings	9/1/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.	The MAO must develop a written notice template for Reconsideration Extensions.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 04 - Benefits and Beneficiary Protections (Access and Availability)	Services Provided with Cultural Competence - The M+CO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds. Does not apply to non-network PFFS plans.	To meet this requirement the MAO must: 1. Provide the MAO's revised policies and procedures to ensure that all MAO services are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds. 2. Conduct training of MAO staff on these policies and procedures and submit documentation that details the nature of the training, the materials used, the dates of training, individuals conducting the training and the individuals trained.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 04 - Benefits and Beneficiary Protections (Delegation)	Oversight of Delegated Entities with Chapter 4 Responsibilities - If any of the activities or responsibilities for the above elements in Chapter 4 are delegated to other parties, the M+CO must oversee them per CMS standards.	To comply with this requirement the MAO must: 1. Establish and maintain effective oversight controls over delegated entities and ensure the MAO maintains compliance for MA operations. 2. Submit policies and procedures that describe the types of oversight activities the MAO will implement over its delegated entities. 2. Provide a schedule of the MAO's oversight activities for its delegated entities. 3. Develop reporting capabilities for oversight of each operational area that is being delegated. 4. Coordinate report format with the RO. 5. When the report format is finalized, implement reporting processes. 6. Beginning with the first month following the CAP acceptance provide the RO with oversight reports for 6 months or until the MAO reaches full compliance, with CMS requirements.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 05 - M+C PFFS Quality Assurance (Quality)	Adequate Health Information System - The M+C PFFS plan must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement and support the activities of the QAPI program.	The organization must enhance its health information system in order to ensure it is capable of collecting, integrating, analyzing and disseminating information throughout the organization and report data that will allow management to efficiently address identified deficiencies, and maintain and sustain compliance in this area.	Closed

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Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 05 - M+C PFFS Quality Assurance (Quality)	Significant Problems Corrected - The M+CO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	The organization must develop and maintain internal oversight of Medicare operations, specifically in the area of grievances. Oversight must include the development of internal audit reports that will allow management the ability to analyze on-going compliance and disseminate information throughout the organization. The organization must appropriately train staff and revise all policies and procedures that impact this area in order to ensure its ability to effectively identify and correct deficiencies and maintain and sustain compliance in this area.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 06 - Provider Relations	Enforcement of Limit - The M+CO must enforce any balance billing limit established by the plan.	To meet the requirement to enforce the balance billing limit the MAO must: 1. Provide a description of processes that the MAO will use to ensure that the balance billing limit is enforced and revise applicable procedures and workflows including all steps in the process, timeframes and the individual responsible to ensure compliance. 2. Develop and implement oversight processes to ensure that issues submitted by beneficiaries are correctly identified and fully resolved. 3. Provide a description of processes to protect beneficiaries when providers refuse to bill Sterling, include timeframes for each step and the individuals responsible to ensure compliance. 4. Develop and implement reports on the MAO's timeliness of response and resolution of balance billing issues 5. Submit these reports to the RO monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the organization reaches full compliance with CMS requirements. 6. Develop and provide procedures for addressing potential fraud complaints under the MA plan.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 06 - Provider Relations	Provider Payment Appeal System - M+C Private fee for service plans must establish and maintain a payment appeal system under which providers may have their payment claims reviewed in the event that a provider believes he was paid less than he would have been paid under Original Medicare. Providers must demonstrate that they have not received proper payment and the plan must then pay the difference between what the provider originally received and what he would have received under Original Medicare.	To comply with the requirement for a provider payment appeal system the MAO must: 1. Provide a description of processes the MAO will use to ensure that providers receive complete responses to all issues in their inquiries. 2. Develop a process for handling corrected claim submissions versus provider payment disputes and provide materials the MAO will use to educate providers on the process. 3. Develop a description of the process the MAO will use to ensure that provider disputes are processed within the MAO's timeliness standards. Include copies of any tools the MAO will use for oversight of the process. 4. Provide a copy of training materials the MAO will use to ensure the MAO's consistency in handling provider complaints including: documentation that details the nature of the training, dates training provided, the individuals conducting the training and the individuals trained. 5. Develop reports on the timeliness of response and resolution of provider payment issues. 6. Submit compliance reports to the RO monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance, with CMS requirements.	Closed

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Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 11 - Contracts	Required Contract Provisions: Abide by Federal Requirements - The M+CO's written contracts, service agreements or terms and conditions of payment with first tier and downstream entities must: 1) contain a provision to show that the contracting entity will comply with Medicare laws, regulations, reporting requirements, and CMS instructions; 2) agree to audits and inspection by CMS and/or its designees; 3) cooperate, assist, and provide information as requested; and 4) maintain records a minimum of 6 years.	To comply with the requirement the MAO must: 1. Establish a mechanism for ongoing oversight of the area responsible for contracting and provide the RO with a description of established oversight mechanisms. 2. Provide CMS with a plan for revising MAO contracts and agreements including, revised language, timing of contract revision and responsible party. 3. Provide CMS with revised contracts.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 11 - Contracts	Adequate Compliance Plan - The M+CO must have a formalized compliance plan that contains the requirements specified by CMS.	To meet this requirement the MAO must: 1. Provide a written compliance plan that includes policies and procedures that describe specific activities to ensure compliance, frequency at which the activities are to be conducted, methodologies to be used for internal audits and the method of documenting and reporting the results to appropriate management staff. 2. Develop and provide the MAO's detailed work plan, including all of the activities to be undertaken and/or overseen by the Compliance Officer and related support staff, timeframes for completion and staff responsible for internal audits.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Organization Determinations and Reconsiderations Not Categorized as Grievances - The M+CO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.	1. The organization must establish and maintain effective oversight controls of grievances. The organization must submit policies and procedures, which describes the type of oversight activities it will implement. Policies and procedures must include responsible staff members and time frames for completion of tasks. 2. The organization must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. 3. The organization must conduct routine internal audits of grievances and submit internal findings to the RO per the instructions of the RO plan manager. 4. The organization must: develop and implement policies and procedures that ensure the organization is also compliant with federal and state grievance requirements, train appropriate staff on these policies and procedures, submit documentation to the regional office that details the nature of this training, including; the materials used in the training, the individuals conducting the training, and the individuals being trained. 5. The organization must review and revise member correspondence in order to ensure that members receive accurate information in language that is clear and understandable to beneficiaries.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Grievances Note)	Grievance Adjudication - The M+CO must adjudicate internal grievances in a manner fully consistent with the M+CO's written grievance procedure, as stated in the EOC.	1.The organization must establish and maintain effective oversight controls of grievances. The organization must submit policies and procedures which describes the type of oversight activities it will implement. Policies and procedures must include responsible staff members and time frames for completion of tasks. 2. The organization must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. 3. The organization should conduct routine internal audits of grievances. The organization should submit a summary report once a quarter to the RO of its monthly findings until further notice. See final report for submission guidance. 4. The organization must: develop and implement policies and procedures that ensure the organization is also complaint with federal and state grievance requirements, train appropriate staff on these policies and procedures, submit documentation to the RO that details the nature of this training, including; the materials used in the training, the individuals conducting the training, and the individuals being trained. 5. The organization must review and revise member correspondence in order to ensure that members receive accurate information in language that is clear and understandable to beneficiaries.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Correct Claim Determinations - The M+CO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the M+CO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	The MAO must revise the policies and procedures that instruct claims processing staff to develop a claim for missing or incorrect information. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the RO that details the nature of the training, including: the curriculum and materials used in training, the individuals who conducted the training, and the staff who attended the training. The MAO must conduct an audit of the denied claims. The audit should evaluate whether the claims processor developed the claims for missing information appropriately, prior to denying the services. In addition, the audit must include verifying the claims processor selected the correct provider of service record. The MAO must submit a summary report monthly to the RO of its findings beginning the first month following acceptance of the CAP. The summary report should include: title and name of the auditor(s), the audit methodology, and the results of the audit findings. The MAO must continue reporting this information to the RO for six consecutive months, or until compliance with CMS requirements is reached and sustained. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance with CMS requirements.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Interest on Clean Claims Paid Late - If the M+CO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and (C).	The MAO must conduct training of appropriate staff on identifying and controlling claims with the correct receipt date. The MAO must submit documentation to the RO that details the nature of the training including: the materials and curriculum used in training, the individuals conducting the training, and the individuals trained. The MAO must establish and maintain effective oversight controls over its delegated entity ASI, to ensure that claims are controlled with the correct receipt date. The MAO must submit a policy and procedure which describes the types of oversight activities it will implement over its delegated entity, to ensure this element is met.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Organization Determinations - Claims)	Claim Denials (Notice Content) - If an M+CO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.	The MAO must conduct training of appropriate staff on applying the appropriate denial code messages on claims, to ensure the beneficiary has a clear understanding of the service denied and the specific reason for the denial. The MAO must submit documentation to the RO that details the nature of the training including: the materials and curriculum used in training, the individuals who are conducting the training, and the individuals trained. The MAO must conduct a monthly internal audit of the denied claims and the denial code messages generated, on the EOBs. This audit must evaluate whether the appropriate denial code message provided on the EOB to the beneficiary was clear and not misleading. The MAO must submit a summary report monthly to the RO of its audit findings, beginning the first month following acceptance of the CAP. The summary report should include: title and name of the auditor(s), the audit methodology, and the audit findings. The MAO must continue reporting this information to the RO for six consecutive months, or until compliance with CMS requirements is reached and sustained. The MAO must provide the RO with a complete listing of EOB and Explanation of Payment (EOP)denial message codes. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Claims)	Favorable Claims Reconsiderations (Timeliness) - If the M+CO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.	Provide CMS with a representative Universe for this element.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - General)	Acceptance of Standard Reconsideration Requests - The M+CO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).	To meet the requirement for acceptance of standard reconsiderations the MAO must: 1. Revise policies and procedures to describe the actual appeal process the MAO uses. Include workflow of the process with timeframes for each step. 2. Develop a description of the process for accepting an appeal when the beneficiary is unable to write. 3. Develop staff training on the revised appeal process and submit documentation that details the nature of the training, dates training provided, the individuals conducting the training and the individuals trained.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - General)	Appropriate Person(s) Conduct the Reconsideration - A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is a denial based on lack of medical necessity, the reconsidered determination must be made by a physician with the expertise in the field of medicine that is appropriate for the service at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.	To comply with the requirement to have appropriate persons conduct the reconsideration: Develop a description of the processes the MAO will use to ensure that persons who were not involved in the initial organization determination conduct the reconsideration. Include updated workflows and a description of staff training on the process.	Closed

Organization Name	Organization Contact	Contract Number(s)	Audit Type	Reason for Corrective Action	Date Corrective Action Plan Requested by CMS	Audit Status	Deficient Area: Chapters	Element Description	Corrective Action Required (CAR)	Corrective Action Plan Status
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the M+CO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The M+CO must concurrently notify the member of this action.	To comply with the requirement the MAO must: 1. Develop a description of the process it will use to ensure the beneficiary's appeal requests are processed correctly. Include copies of revised procedures and workflows. 2. Develop a description of the oversight process the MAO will implement to ensure compliance in this area. 3. Develop training for MAO staff responsible for appeals and submit documentation that details the nature of the training, dates training provided, the individuals conducting the training and the individuals trained.	Closed
Munich American Holding Corporation	1-360-647-9080 Ext. 29098	H5006	MA	Audit Findings	8/14/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals (Reconsiderations - Pre Service)	Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize the service within 72 hours from the date it receives the notice reversing the determination, provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date), or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal, or pay the claim following the plan's normal claims processing procedures.	To meet the requirement to effectuate reversals the MAO must: 1. Provide a description of processes the MAO will use to assure that beneficiary's appeal requests are processed correctly and all steps are completed in the process. Include copies of revised procedures and workflows. 2. Develop a description of the oversight process the MAO will implement to ensure compliance in this area. 3. Develop staff training on these policies and procedures and submit documentation that details the nature of the training, dates training provided, the individuals conducting the training and the individuals trained.	Closed
Humana Inc.	1-502-580-3683	H2949	MA	Audit Findings	5/30/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.	PCNV must continue to monitor the accuracy of denial determinations made by its delegated claims processing entity. PCNV must implement a more comprehensive oversight program to address the delegate's failure to make appropriate determinations on non-contracted provider claims. Please submit evidence of the oversight process currently in place and the enhancements made to the program to specifically address the issue of incorrect denial determinations.	Closed
Health Alliance Medical Plans	1-217-255-4544	H1463	MA	Audit Findings	3/31/2006	Closed	Chapter 13 - Organization Determinations, Grievances, and Appeals	Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.	HAMP must review and adhere to their internal policies to ensure that clean claims are processed within CMS' mandated time frame of 30 days.	Closed